DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 7: VA Southeast Network in Duluth, Georgia

CHIP REPORT | **REPORT #20-00130-86** | **MARCH 3, 2021**

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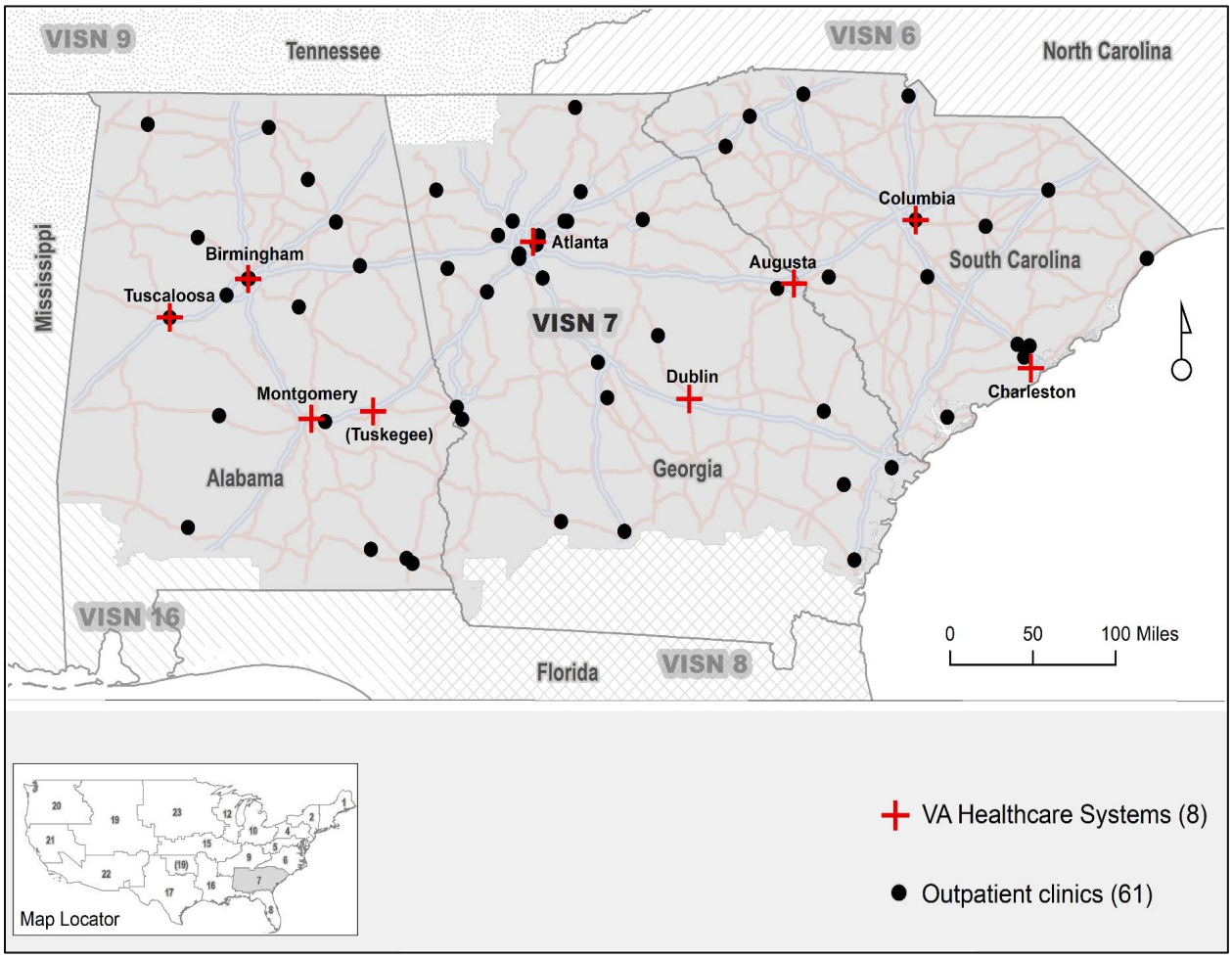

Figure 1. *VA Southeast Network–Veterans Integrated Service Network 7 in Duluth, Georgia.*
Source: Veterans Administration Site Tracking, December 16, 2019.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
FTE	full-time equivalent
FY	fiscal year
HCS	health care system
OIG	Office of Inspector General
QMO	quality management officer
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SPS	Sterile Processing Services
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by the Veterans Integrated Service Network (VISN) 7: VA Southeast Network. The inspection covers key clinical and administrative processes 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 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 areas:

1. Quality, safety, and value
2. Medical staff credentialing
3. Environment of care
4. Medication management (targeting long-term opioid therapy for pain)
5. Women's health (examining comprehensive care)
6. High-risk processes (emphasizing reusable medical equipment)

The OIG conducted this unannounced visit during the week of March 2, 2020. Inspections of the following VISN 7 facilities were also performed during the weeks of February 24, 2020, and March 2, 2020:

- Atlanta VA Health Care System (HCS) (Decatur, Georgia)
- Birmingham VA Medical Center (VAMC) (Alabama)
- Carl Vinson VAMC (Dublin, Georgia)
- Central Alabama Veterans HCS (Montgomery and Tuskegee)
- Charlie Norwood VAMC (Augusta, Georgia)[1]
- Ralph H. Johnson VAMC (Charleston, South Carolina)
- Tuscaloosa VAMC (Alabama)
- Wm. Jennings Bryan Dorn VAMC (Columbia, South Carolina)

[1] The Charlie Norwood VAMC is a two-division medical center that includes the Downtown and Uptown Divisions.

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient care outcomes. The findings presented in this report are a snapshot of VISN 7 and facility performance within the identified focus areas at the time of the OIG visit and may help VISN leaders identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued seven recommendations that are attributable to the Network Director. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

The VISN leadership team consists of the acting Network Director, Deputy Network Director, acting Chief Medical Officer, Quality Management Officer, and Chief Operating Officer. Organizational communication and accountability are managed through a committee reporting structure, with the VISN's Executive Leadership Council overseeing the Healthcare Delivery; Healthcare Operations; Organizational Health; and Quality, Safety and Value Committees.

In September 2019, VHA reassigned the Network Director and Chief Medical Officer and appointed an acting Network Director and acting Chief Medical Officer following reports that an elderly patient at the Atlanta VA HCS's Eagles' Nest Community Living Center was bitten by ants prior to his death from cancer. As a result, at the time of the OIG's inspection, the VISN leadership team had worked together for almost five months.

Selected survey scores related to employees' satisfaction with the VISN executive team leaders revealed opportunities for the acting Chief Medical Officer to improve attitudes towards leadership. In review of patient experience survey data, the OIG noted VISN averages for each of the selected survey questions were lower than VHA averages. The VISN leaders acknowledged the survey scores and appeared to be working to improve employee engagement and patient satisfaction.

The OIG's review of primary care and mental health access metrics and clinical vacancies identified potential organizational risk factors. Clinical staffing may be a contributing factor in primary care wait time challenges at the Atlanta VA HCS, Central Alabama Veterans HCS, and Tuscaloosa VAMC. Additionally, clinical staffing may affect mental health wait times at the Carl Vinson and Charlie Norwood VAMCs, and the Central Alabama HCS.

Interviewed leaders were knowledgeable about efforts taken to reduce veteran suicide in VISN 7 and shared information that highlighted efforts to develop and implement strategies for high-risk veterans.

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have 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.[2]

The leadership team was knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning and Community Living Center metrics and should continue to take actions to sustain and improve performance. However, the OIG identified that the Network Director, Chief Medical Officer, and Quality Management Officer had opportunities to improve their oversight of facility-level quality, safety, and value; medical staff privileging; medication management; mental health; care coordination; women's health; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

Environment of Care

The OIG found general compliance with the assessment of inventory management programs. However, the OIG noted concerns with the comprehensive environment of care program policy and annual reviews of the VISN Emergency Operations Plan; Continuity of Operations Plan; Hazards Vulnerability Analysis; and VISN-wide strengths, weaknesses, priorities, and requirements for improvement.

Women's Health

The VISN complied with requirements for a lead women veterans program manager, VISN-level support staff, and access and satisfaction data analysis. However, the OIG identified deficiencies with quarterly program updates to executive leaders, annual site visits, and staff educational gap assessments.

High-Risk Processes

The VISN complied with requirements for the establishment of a Sterile Processing Services management board and the completion of VISN-led facility reusable medical equipment inspections. However, the OIG noted concerns with the posting of inspection results and oversight of facility corrective action plan development.

[2] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center (VSSC), accessed March 6, 2020, https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428. (This is an internal website not publicly accessible.)

Conclusion

The OIG conducted a detailed inspection across seven key areas and subsequently issued seven recommendations for improvement to the Network Director. The number of recommendations should not be used, however, as a gauge for the overall quality of care provided within this VISN. The intent is for VISN leaders to use these recommendations as a road map to help improve operations and clinical care throughout the network of assigned facilities. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director agreed with the Comprehensive Healthcare Inspection Program findings and recommendations and provided acceptable improvement plans. (See appendix G, page 52, and the responses within the body of the report for the full text of the Network Director's comments.) The OIG has received evidence of compliance and considers recommendation 1 closed. 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 this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by the Veterans Integrated Service Network (VISN) 7: VA Southeast Network. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN 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]

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

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff credentialing
4. Environment of care
5. Medication management (targeting long-term opioid therapy for pain)
6. Women's health (examining comprehensive care)
7. High-risk processes (emphasizing reusable medical equipment)

[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): e005055.

[3] Danae Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5(4), (December 2017): 73.

Methodology

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

The inspection examined operations from January 23, 2017, through March 6, 2020, the last day of the unannounced week-long site visit.[4]

Inspections of the following VISN 7 facilities were also performed during the weeks of February 24, 2020, and March 2, 2020:

- Atlanta VA Health Care System (HCS) (Decatur, Georgia)
- Birmingham VA Medical Center (VAMC) (Alabama)
- Carl Vinson VAMC (Dublin, Georgia)
- Central Alabama Veterans HCS (Montgomery and Tuskegee)
- Charlie Norwood VAMC (Augusta, Georgia)[5]
- Ralph H. Johnson VAMC (Charleston, South Carolina)
- Tuscaloosa VAMC (Alabama)
- Wm. Jennings Bryan Dorn VAMC (Columbia, South Carolina)

While on site, the OIG did not receive any complaints beyond the scope of the CHIP site visit.

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 VISN leaders complete corrective actions. The Network Director's responses to the report recommendations appear

[4] The range represents the time from the last Clinical Assessment Program visit of the Atlanta VA Medical Center to the completion of the unannounced week-long CHIP site visit on March 6, 2020 (see appendix D).

[5] The Charlie Norwood VAMC is a two-division medical center, which includes the Downtown and Uptown Divisions.

[6] Pub. L., No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3).

within each topic area. The OIG accepted the action plans that the VISN 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.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can affect the ability to provide care in the clinical focus areas.[7] To assess the VISN's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Access to care
5. Clinical vacancies
6. VISN efforts to reduce veteran suicide
7. Oversight inspections
8. VHA performance data

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility CHIP site visits performed during the weeks of February 24, 2020, and March 2, 2020.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the veterans' healthcare system.[8]

VISN 7 is responsible for oversight of eight healthcare systems and 61 outpatient clinics. According to data from the VA National Center for Veterans Analysis and Statistics, VISN 7 was projected to have a veteran population of 1,330,040 within its borders at the end of fiscal year 2020.

[7] Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper. Cambridge, MA: 2006.

[8] Detailed explanation of VISNs provided by Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, May 22, 2018.

VISN 7 has a leadership team consisting of the acting Network Director, Deputy Network Director, acting Chief Medical Officer (CMO), Quality Management Officer (QMO), and Chief Operating Officer. The CMO is responsible for overseeing facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.

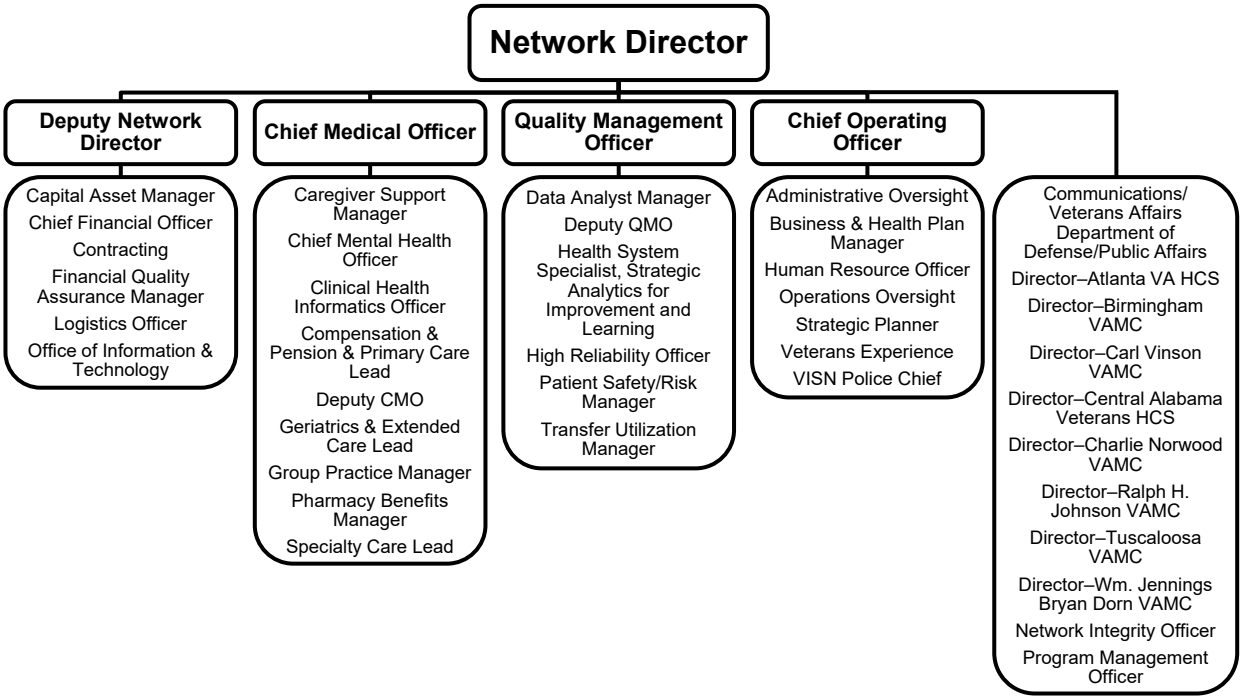

Figure 2. *VISN 7 organizational chart*[9]
Source: VA Southeast Network (received March 4, 2020)

In September 2019, VHA reassigned the Network Director and CMO and appointed an acting Network Director and acting CMO following reports that an elderly patient at the Atlanta VA HCS's Eagles' Nest Community Living Center (CLC) was bitten by ants prior to his death from cancer (see table 1).[10] As a result of the staffing changes, at the time of the OIG site visit, the VISN leadership team had worked together for almost five months.

[9] For this VISN, the Network Director is responsible for the directors of the Atlanta VA HCS (Decatur, Georgia); Birmingham VAMC (Alabama); Carl Vinson VAMC (Dublin, Georgia); Central Alabama Veterans HCS (Montgomery and Tuskegee); Charlie Norwood VAMC (Augusta, Georgia); Ralph H. Johnson VAMC (Charleston, South Carolina); Tuscaloosa VAMC (Alabama); and Wm. Jennings Bryan Dorn VAMC (Columbia, South Carolina).

[10] VA Office of Public and Intergovernmental Affairs, "VA Takes Action to Restore Trust at Atlanta VAMC's Eagles' Nest Community Living Center," news release, September 17, 2019, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5316.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	September 17, 2019 (acting)
Deputy Network Director	September 15, 2019
Chief Medical Officer	October 27, 2019 (acting)
Quality Management Officer	April 2, 2017
Chief Operating Officer	October 13, 2019

Source: VA Southeast Network (received March 4, 2020)

To help assess VISN executive leaders' engagement, the OIG interviewed the acting Network Director, Deputy Network Director, acting CMO, and QMO regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. Leaders also had a sound understanding of CLC SAIL metrics. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The leaders are members of the VISN's Executive Leadership Council, which is responsible for processes that enhance network performance by

- Providing strategic direction, deployment and measurement of performance, accountability, and transparency of decision-making;
- Serving as a forum for making recommendations to the Network Director;
- Recommending approval of VISN policies for dissemination, communication, and implementation;
- Assuring the Council's actions and initiatives are supportive of the vision, values, and mission of VISN 7 and aligned with the Blueprint for Excellence, strategic direction, and goals of VHA and VA; and
- Supporting the ethical behavior of VISN committees.

The Network Director serves as the chairperson of the Executive Leadership Council, which has oversight of the Healthcare Delivery; Healthcare Operations; Organizational Health; and Quality, Safety and Value Committees (see figure 3).

Figure 3. *VISN 7 committee reporting structure*
Source: VA Southeast Network (received March 4, 2020)

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health. 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 VISN leadership.

To assess employee attitudes toward VISN and facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2018, through September 30, 2019. Table 2 summarizes survey results for VHA, the VISN office, and VISN leaders.[12] The OIG found the VISN office scores for the selected survey leadership questions were similar to those for VHA. The VISN leaders' scores were generally

[11] "VA Workforce Surveys Portal," VHA Support Service Center, accessed November 30, 2020, http://aes.vssc.med.va.gov/Documents/04_AES_History_Concepts.pdf.

[12] Ratings are based on responses by employees who report to or are aligned under the Network Director, Deputy Network Director, CMO, and QMO. Data are not available for the Chief Operating Officer.

better than the VHA and VISN office scores, except for the CMO, who had opportunities to improve attitudes towards leadership across all selected questions.[13]

Table 2. Survey Results on Employee Attitudes toward VISN 7 Leadership (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	VISN 7 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: *Servant Leader Index Composite*[*]	0–100 where HIGHER scores are more favorable	72.6	71.7	96.4	–[†]	67.9	91.0
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.5	4.7	3.7	2.7	4.2

[13] 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. It is important to note that the results are not reflective of the current acting Network Director, Deputy Director, and acting CMO, who assumed the positions after the All Employee Survey was administered.

Questions/ Survey Items	Scoring	VHA Average	VISN 7 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	4.6	3.4	3.1	4.2
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	4.7	3.8	3.3	4.4

Source: VA All Employee Survey (accessed February 4, 2020)

** The Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."*
† Data are not available due to a low number of respondents.

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The leadership team averages for employee attitudes toward the workplace were generally better than the VHA averages, with the exception of the Deputy Network Director and QMO's results in the area of moral distress at work. Executive leaders shared survey results with staff and created employee workgroups to identify improvement goals for the coming year. Overall, VISN leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns.

Table 3. Survey Results on Employee Attitudes toward the VISN 7 Workplace (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	VISN 7 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	4.9	3.7	3.9	5.0
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.7	4.4	3.8	3.8	3.2
All Employee Survey: In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?	0 (Never) – 6 (Every Day) lower is better.	1.4	1.4	1.3	2.4	0.7	1.8

Source: VA All Employee Survey (accessed February 4, 2020)

Patient Experience

To assess patient attitudes toward their healthcare experiences, the OIG reviewed patient experience survey results that relate to the period of October 1, 2018, through September 30, 2019. 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 to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for VISN 7 and compares the results to the overall VHA averages.[14]

VHA also collects Survey of Healthcare Experiences of Patients survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their healthcare experiences (see table 4). The VISN average for each of the selected survey questions was lower than the VHA average, indicating that VISN 7 patients are generally less satisfied compared to VHA patients in general.

To improve patient satisfaction scores, the VISN utilized additional survey tools through a contracted patient satisfaction consulting firm that provides data at the individual provider level and Veteran Signals, which surveys randomly selected veterans about recent outpatient experiences.[15] The OIG found that the VISN Veterans Experience Officer conducted site visits at all VISN facilities and provided training at both the Atlanta VA and Central Alabama Veterans HCSs to assist in data analysis and action plan development for improved provider-patient communication and care transitions. VISN 7 facility scores for the selected questions are presented in appendix C.

[14] Ratings are based on responses by patients who received care within the VISN.

[15] VA, "VA Customer Profile and Veterans Signals programs recognized by FedHealthIT," *VAntage Point* (blog), June 18, 2019, https://www.blogs.va.gov/VAntage/61703/va-customer-profile-veterans-signals-programs-recognized-fedhealth/. Veterans Signals is a VHA survey sent to veterans who received outpatient services within the previous week. Surveys remain open for two weeks after the invitation is sent. The feedback veterans submit is used to quickly help inform opportunities for service recovery and performance improvement.

Table 4. Survey Results on Patient Attitudes within VISN 7 (October 1, 2018, through September 30, 2019)

Questions	Scoring	VHA Average	VISN 7 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	61.1
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	81.1
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	71.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	72.0

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed February 4, 2020)

Access to Care

A VA priority is achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans. VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[16] VHA has utilized various measures to determine whether access goals are met for both new and established patients, including wait

[16] VHA Directive 1230(3), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 7, 2021. The "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

time statistics based on appointment creation and patient preferred dates.[17] Wait time measures based on "create date" have the advantage of not relying upon the accuracy of the "preferred date" entered into the scheduling system and are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, that includes a "clinically indicated date." The disadvantage of "create date" metrics is that wait times do not account for specific patient requests or availability. Wait time measures based on patient preferred dates consider patient preferences but rely upon appointment schedulers accurately recording the patients' wishes into the scheduling software.[18]

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, they became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[19] However, with the passage of the VA MISSION Act of 2018 on June 6, 2018, and subsequent enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[20]

- Average drive time
  - 30-minute average drive time for primary care, mental health, and non-institutional extended care services
  - 60-minute average drive time for specialty care
- Appointment wait time
  - 20 days for primary care, mental health care, and non-institutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider
  - 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA health care provider

To examine access to primary and mental health care within VISN 7, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary care and mental health clinics for the most recently completed quarter. Tables 5 and 6 provide wait time statistics

[17] "Completed appointments cube data definitions," VA Business Intelligence Office, accessed March 28, 2019, https://bioffice.pa.cdw.va.gov/. (This is an internal VA website not publicly accessible.)

[18] Office of Veterans Access to Care, *Specialty Care Roadmap*, November 27, 2017.

[19] VHA Directive 1700, *Veterans Choice Program*, October 25, 2016.

[20] VA MISSION Act of 2018, Pub. L. No. 115-182, Stat. 1393; VA Office of Public Affairs Media Relations, "Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018," April 2019.

for completed primary care and mental health appointments from October 1, 2019, through December 31, 2019.[21]

Table 5. Primary Care Appointment Wait Times (October 1 through December 31, 2019)

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VA Southeast Network	11,416	21.3
Atlanta VA HCS (Decatur, GA)	2,730	31.0
Birmingham VAMC (AL)	1,554	21.1
Carl Vinson VAMC (Dublin, GA)	802	14.3
Central Alabama Veterans HCS (Montgomery and Tuskegee)	1,188	28.3
Charlie Norwood VAMC (Augusta, GA)	957	16.7
Ralph H. Johnson VAMC (Charleston, SC)	2,091	16.1
Tuscaloosa VAMC (AL)	257	21.7
Wm. Jennings Bryan Dorn VAMC (Columbia, SC)	1,837	13.6

Source: VHA Support Service Center (accessed February 4, 2020)
Note: The OIG did not assess VA's data for accuracy or completeness.

Table 6. Mental Health Appointment Wait Times (September 1 through December 31, 2019)

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VA Southeast Network	3,472	15.2
Atlanta VA HCS (Decatur, GA)	457	7.2
Birmingham VAMC (AL)	621	18.3
Carl Vinson VAMC (Dublin, GA)	469	24.2
Central Alabama Veterans HCS (Montgomery and Tuskegee)	608	19.4
Charlie Norwood VAMC (Augusta, GA)	328	13.5
Ralph H. Johnson VAMC (Charleston, SC)	468	7.7

[21] Reported primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine, and records visits for comprehensive primary care services. Reported mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual, and records visits for the evaluation, consultation, and/or treatment by staff trained in mental diseases and disorders.

Facility	New Patient Appointments	Average New Patient Wait from Create Date
Tuscaloosa VAMC (AL)	116	14.7
Wm. Jennings Bryan Dorn VAMC (Columbia, SC)	405	18.1

Source: VHA Support Service Center (accessed February 4, 2020)
Note: The OIG did not assess VA's data for accuracy or completeness.

Based upon wait times alone, the MISSION Act may improve access to primary care for patients in the Atlanta VA HCS, Birmingham VAMC, Central Alabama Veterans HCS, and Tuscaloosa VAMC, where the average wait time for new primary care appointments is approximately 31, 21, 28, and 22 days, respectively. The MISSION Act may improve mental health wait times at the Carl Vinson VAMC, where the average wait time for new mental health appointments is roughly 24 days. Wait times also highlight opportunities for these facilities to improve the timeliness of primary care provided "in house" and thus decrease the potential for fragmented care among patients referred to community providers.

The OIG found that the CMO reviewed and monitored access statistics daily for VISN facilities, including wait times for new primary care and mental health patients. Additionally, facility and VISN group practice managers evaluated access data by tracking the number of patients seeking non-VA care to determine if drive times, wait times, or other factors influenced community care use. The facility group practice managers also identified a population growth of 20,000 patients in the Atlanta VA HCS catchment area. As a result, VISN leaders planned to establish new sites of care within the greater Atlanta area to expand access and ease the burden on existing Atlanta VA HCS clinics.

VISN leaders provided primary care and mental telehealth services via VA Video Connect to improve access at the Atlanta VA HCS, Carl Vinson VAMC, and Central Alabama Veterans HCS.[22] Other VISN 7 telehealth services included dermatology, optometry, and ophthalmology.

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover—or instability—and high clinical vacancy rates negatively affect access to care, the quality of health care provided,

[22] "VA Mobile: Veterans VA Video Connect," VA, accessed April 24, 2020, https://www.mobile.va.gov/app/va-video-connect. VA Video Connect allows veterans to see and talk with their health care team from anywhere. It uses encryption to ensure a secure and private session. This technology makes VA health care more convenient and reduces travel times for veterans, especially those in very rural areas with limited access to VA health care facilities. It also allows quick and easy health care access from any mobile or web-based device.

patient safety, and patient and staff satisfaction. Turnover and the loss of experienced staff can directly affect staffing levels and further reduce employee and organizational performance.[23]

To assess the potential impact of clinical vacancies on primary care and mental health wait times across VISN 7 facilities, the OIG held discussions with the Human Resources Officer and reviewed the total number of vacancies by facility, position, and full-time employee equivalents (FTE). Table 7 provides the VISN 7 facilities' number of clinical vacancies and vacancy rates for primary care physicians, physician assistants, nurse practitioners, and nurses as of March 4, 2020.

Table 7. Reported Primary Care Vacancy Rates for VISN 7 Facilities (as of March 4, 2020)

Facility	Clinical Vacancies	Clinical Vacancy Rate
Atlanta VA HCS (Decatur, GA)	74	23.5%
Birmingham VAMC (AL)	7	5.0%
Carl Vinson VAMC (Dublin, GA)	32	27.1%
Central Alabama Veterans HCS (Montgomery and Tuskegee)	23	17.0%
Charlie Norwood VAMC (Augusta, GA)	16	24.3%
Ralph H. Johnson VAMC (Charleston, SC)	8	4.7%
Tuscaloosa VAMC (AL)	7	15.9%
Wm. Jennings Bryan Dorn VAMC (Columbia, SC)	14	24.1%

Source: VA Southeast Network Human Resources Officer (received March 4, 2020)

Clinical staffing may be a contributing factor to primary care wait time challenges at the Atlanta VA HCS, Central Alabama Veterans HCS, and Tuscaloosa VAMC, where overall clinical vacancy rates were 23.5, 17.0, and 15.9 percent, respectively.

Table 8 provides mental health vacancy data for psychiatrists, psychologists, social workers, and nurses as of March 4, 2020.

[23] James Buchanan, "Reviewing the Benefits of Health Workforce Stability," *Human Resources for Health* 8, no. 29 (December 2010).

Table 8. Reported Mental Health Vacancy Rates for VISN 7 Facilities (as of March 4, 2020)

Facility	Clinical Vacancies	Clinical Vacancy Rate
Atlanta VA HCS (Decatur, GA)	86	13.6%
Birmingham VAMC (AL)	18	7.1%
Carl Vinson VAMC (Dublin, GA)	44	29.1%
Central Alabama Veterans HCS (Montgomery and Tuskegee)	51	22.4%
Charlie Norwood VAMC (Augusta, GA)	39	44.3%
Ralph H. Johnson VAMC (Charleston, SC)	26	9.6%
Tuscaloosa VAMC (AL)	6	5.1%
Wm. Jennings Bryan Dorn VAMC (Columbia, SC)	17	16.8%

Source: VA Southeast Network Human Resources Officer (received March 4, 2020)

Clinical staffing may be a contributing factor to mental health wait times at the Carl Vinson VAMC, where five psychiatrist and 15 psychologist FTEs were vacant, and the overall clinical vacancy rate was 29.1 percent; the Charlie Norwood VAMC, where six psychiatrist and 17 psychologist FTEs were vacant, and the overall clinical vacancy rate was 44.3 percent; and the Central Alabama Veterans HCS, where three psychiatrist and 22 psychologist FTEs were vacant, and the overall clinical vacancy rate was 22.4 percent.

The Human Resources Officer reported that "time-to-hire" statistics are provided to the Network Director, who holds bi-weekly meetings with leaders of VISN medical centers to track the timeliness of hiring to fill existing or anticipated vacancies. The VISN Mental Health Lead reported mental health staffing ratios and hiring updates to the Executive Leadership Council quarterly.

VISN Efforts to Reduce Veteran Suicide

Suicide is a leading cause of death in the United States, and suicide rates in almost all states increased from 1999 through 2016.[24] Although the unadjusted rate of suicide among veterans decreased from 30.5 to 30.1 per 100,000 veterans from 2015 to 2016, the suicide rate for veterans age 18 to 34 has risen substantially since 2005. With approximately 20 million veterans in United States, the number of veterans who die by suicide annually is significant.[25] Further, the

[24] "Vital Signs: Suicide rising across the US," The Centers for Disease Control and Prevention, accessed March 10, 2020, https://www.cdc.gov/vitalsigns/suicide/index.html.

[25] "Mental Health: Suicide Prevention," Department of Veterans Affairs, accessed June 22, 2020, https://www.mentalhealth.va.gov/suicide_prevention/.

suicides of three veterans at VA facilities in Georgia and Texas within five days in April 2019 garnered congressional and media interest.[26]

VA has made suicide prevention its top priority with the Office of Mental Health and Suicide Prevention by implementing significant suicide prevention initiatives: expansion of the Veterans Crisis Line to three call centers, release of a suicide prevention training video,[27] launch of the Mayor's Challenge,[28] and partnership with the departments of Defense and Homeland Security to support veterans during their transition from military to civilian life.[29]

The OIG found that VISN 7 leaders were knowledgeable about facilities' efforts to reduce veteran suicide and noted that they shared information highlighting endeavors to develop and implement strategies for high-risk veterans. Leaders acknowledged challenges that arose after the occurrence of two suicides on VISN 7 campuses in April 2019 and discussed actions taken since to improve suicide prevention efforts.

The OIG found that VISN 7 leaders appeared engaged and supportive of facilities' efforts to prevent veteran suicides and noted the following:

- Development of facility-based suicide prevention councils to enhance coordination of suicide prevention services
- Production of a suicide prevention simulation training video, "Identifying Veterans in Distress"
- Participation by three VISN medical centers in a pilot program established by the Clay Hunt Suicide Prevention for American Veterans Act, which provides peer support and improves and access to mental health services for veterans[30]

VISN leadership opined that resources and funding for VHA suicide prevention efforts were generally satisfactory. However, the leaders suggested that more flexibility in funding

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[26] ABC News, "Legislation to address uptick of veteran suicides at VA facilities," news release, April 18, 2019, https://abcnews.go.com/Politics/legislation-address-uptick-veteran-suicides-va-facilities/story?id=62462330.

[27] VA Office of Public and Intergovernmental Affairs, "VA and PsychArmor Institute Offer Online Suicide Prevention Training," news release, June 18, 2018, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4071. VA Operation S.A.V.E. outlines steps for staff to help veterans, including signs of suicidal thinking, ask questions, validate the veteran's experience, encourage treatment, and expedite getting help.

[28] VA Office of Public and Intergovernmental Affairs, "VA continues community suicide-prevention challenge," news release, April 1, 2019, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5230. "The Mayor's Challenge was launched in March 2018, bringing together representatives of eight cities to develop local action plans to prevent Veteran suicide. Since then, the Mayor's Challenge program has expanded to a total of 24 cities. An inaugural Governor's Challenge that involved seven state teams took place in February, replicating the effort on the state level. Participants in both programs form interagency teams to bolster Veteran suicide-prevention efforts in their communities."

[29] VA Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016,* September 2018.

[30] Clay Hunt Suicide Prevention for American Veterans Act, Pub. L. No. 114-2, Stat. 30.

authorizations at the medical center level would allow facility leaders to address issues unique to that facility or region that may have the most impact on prevention efforts.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. Except for those made in recently published reports, VISN and facility leaders had closed all recommendations for improvement listed in appendix D.[31]

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have 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.[32]

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of June 30, 2019. Of note, the figure shows metrics in the first and second quintiles (blue and green data points) that demonstrate high performance (for example, in the areas of complications, call responsiveness, and continued (cont) stay reviews met). The OIG also noted metrics in the fourth and fifth quintiles (orange and red data points) that need improvement (for example, registered nurse (RN) turnover, care transition, standardized mortality ratio (SMR), and best place to work).[33]

[31] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations.

[32] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020, https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428. (This is an internal VA website not publicly accessible.)

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

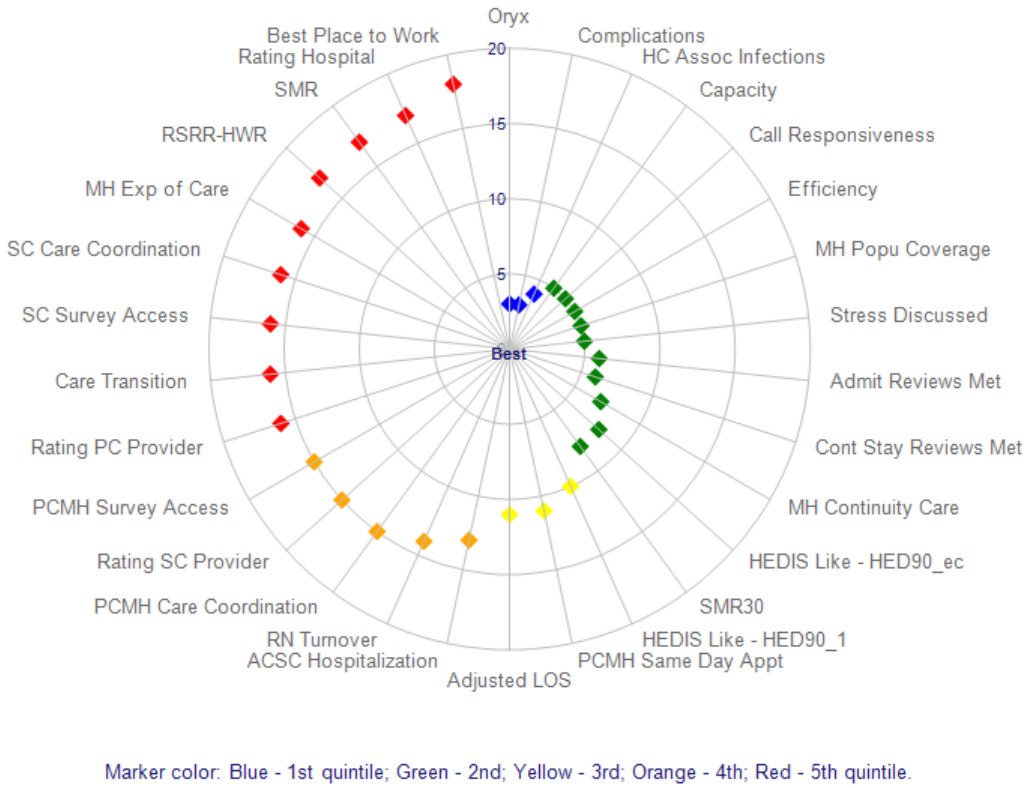

Figure 4. *Facility quality of care and efficiency metric rankings for fiscal year (FY) 2019 quarter 3 (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Data definitions are provided in appendix E.

VISN leaders noted that many of the fifth quintile performance measures were related to patient and employee satisfaction. To improve employee satisfaction and performance in the best place to work measure, VISN leaders encouraged employee participation in the surveys and established facility-level employee workgroups that gave local leaders data-driven feedback and focused on the concerns of dissatisfied employees.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in

the Centers for Medicare & Medicaid Services' *Nursing Home Compare*.[34] The SAIL CLC provides a single resource to review quality measures and health inspection results.

The SAIL CLC includes a radar diagram showing CLC performance relative to other CLCs for all 16 quality measures. Figure 5 illustrates the VISN's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2019. Again, the OIG noted high performance across multiple first and second quintile metrics, denoted with blue and green data points (for example, in the areas of physical restraints—long-stay (LS), moderate-severe pain—short-stay (SS), and falls with major injury (LS)). The OIG also discussed concerns regarding measures in the fourth and fifth quintiles, denoted with orange and red data points (for example, moderate-severe pain (LS) and improvement in function (SS)).[35]

[34] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, July 23, 2020. "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."

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

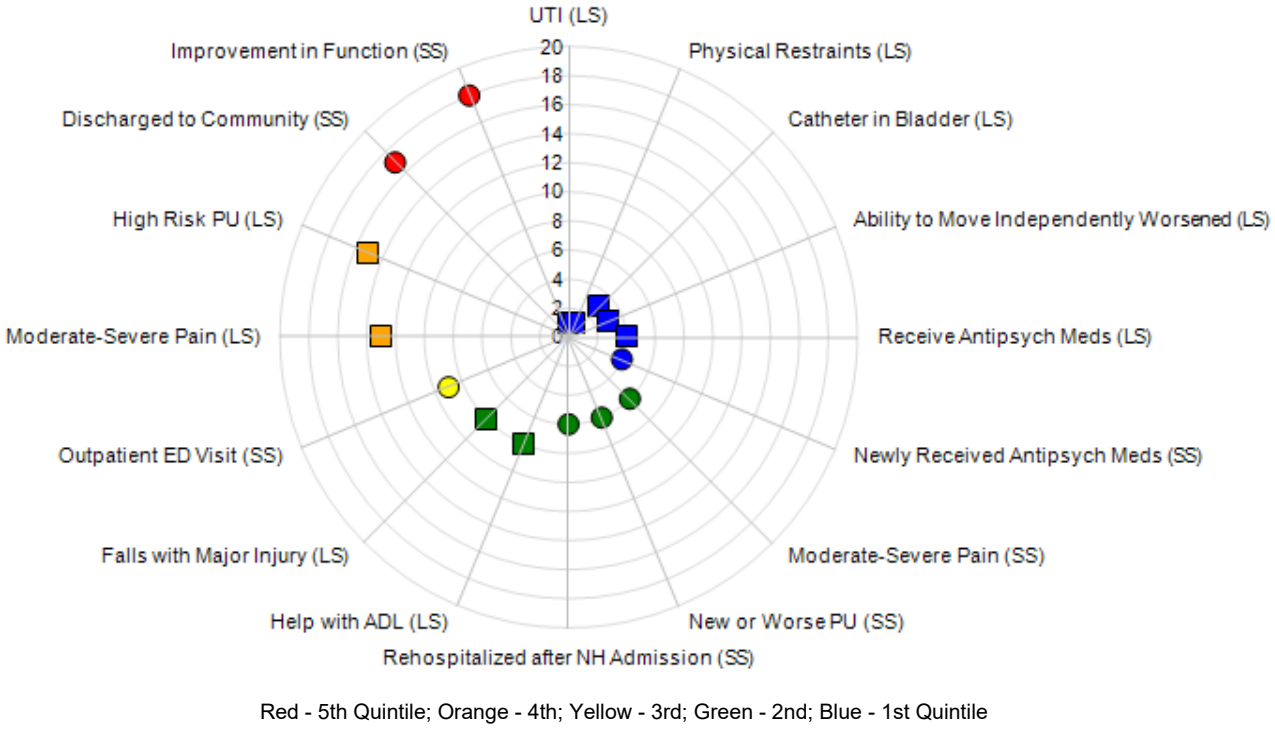

***Figure 5**. CLC quality measure rankings for FY 2019 quarter 4 (as of September 30, 2019)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see appendix F.

The VISN leaders acknowledged issues with the Atlanta VA HCS's Eagles' Nest CLC, where a veteran suffered more than a hundred ant bites. After the incident, the VISN Deputy Director, CMO, and QMO completed a site visit; and the QMO detailed a VISN nurse staff member to the CLC to assist in incident assessment, action planning, and implementation.

Observed Trends in Noncompliance

During CHIP visits of the VISN 7 facilities performed during the weeks of February 24, 2020, and March 2, 2020, the OIG noted trends in noncompliance for the following areas:

- Quality, safety, and value
  - Documentation and implementation of action items when problems or opportunities for improvement are identified
  - Required review and documentation of root cause analyses
- Medical staff privileging
  - Use of service-specific criteria and data collection in professional practice evaluations

  - Completion of professional practice evaluations by providers with similar training and privileges
  - Review of professional practice evaluations by the Medical Executive Committee in the decision to recommend new or continuing privileges
  - Timely completion of provider exit review forms
- Medication management (specifically long-term opioid therapy for pain)
  - Assessment of aberrant behavior risk
  - Completion of urine drug testing
  - Documentation of informed consent
- Mental health (focusing on the suicide prevention program)
  - Initial and annual suicide prevention training for staff
- Care coordination (spotlighting life-sustaining treatment decisions)
  - Documentation of goals of care conversations
- Women's health (examining comprehensive care)
  - Assignment of required members to the women's health committee
  - Designation of community-based outpatient clinic women's health primary care providers
- High-risk processes (emphasizing reusable medical equipment)
  - Completion of annual airflow testing
  - Reporting of annual risk analysis results to the VISN Sterile Processing Services Management Board
  - Staff completion of competency assessments and monthly continuing education

Leadership and Organizational Risks Conclusion

The VISN's executive leadership team was in a state of transition, with an acting Network Director and acting CMO performing their duties after the previous Network Director and CMO were reassigned. The executive leadership team had served together for almost five months prior to the OIG's site visit.

Selected survey scores related to employees' satisfaction with the VISN executive team leaders revealed opportunities for the acting CMO to improve attitudes towards leadership and the Deputy Network Director and QMO to improve results in the area of moral distress at work. In review of patient experience survey data, the OIG noted VISN averages for each of the selected

survey questions were lower than VHA averages. The VISN leaders acknowledged the survey scores and appeared to be working to sustain and improve employee engagement and patient satisfaction.

The executive team leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as closely monitoring "time-to-hire" data and opening new clinics in the greater Atlanta area for improved patient access).

The OIG's review of primary care and mental health access metrics and clinician vacancies identified potential organizational risk factors. Clinical staffing may be a contributing factor to primary care wait time challenges at the Atlanta VA HCS, Central Alabama Veterans HCS, and Tuscaloosa VAMC. Additionally, clinical staffing may be affecting mental health wait times at the Carl Vinson and Charlie Norwood VAMCs, and the Central Alabama Veterans HCS. The leadership team was generally knowledgeable within their scope of responsibilities about selected SAIL and CLC metrics and should continue to take actions to sustain and improve performance.

Further, the OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level quality, safety, and value; medical staff privileging; medication management; mental health; care coordination; women's health; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

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.[36] 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.[37] Designated leaders are directly accountable for program integration and communication within their level of responsibility. Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[38]

To determine whether the VISN implemented and incorporated OIG-identified key processes for quality and safety, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, OIG inspectors examined completion of the following:

- Written utilization management plan
- Annual utilization management program summary reviews[39]
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[40]
    - Monitoring of facility outlier data and communication of follow-up actions to the VISN Director and System/VAMC Director
    - Submission of quarterly VISN peer review data analysis reports to the Office of Quality, Safety, and Value
- Quarterly reporting of institutional disclosures for each facility[41]

Quality, Safety, and Value Findings and Recommendations

Generally, the VISN achieved the requirements listed above. The OIG made no recommendations.

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

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

[38] *Veterans Health Administration Blueprint for Excellence*.

[39] VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019. This directive was replaced by VHA Directive 1117 on October 8, 2020.

[40] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.

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

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[42] When certain actions are taken against a provider's licenses, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the provider meets licensure requirements for VA employment.[43] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a through documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO. The Deputy Under Secretary for Health for Operations and Management is responsible for ensuring that VISN directors maintain an appropriate credentialing and privileging process consistent with VHA policy, which includes VISN CMO oversight of facilities' processes.[44]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[45] When reports from the National Practitioner Data Bank and/or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

- Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements,
- Regional Counsel or designee's documented review to determine if the physician meets appointment requirements, and
- VISN CMO concurrence and approval of the Regional Counsel or designee's review.

Medical Staff Credentialing Findings and Recommendations

Generally, the VISN met the above requirements. The OIG made no recommendations.

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[42] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

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

[44] VHA Handbook 1100.19.

[45] GAO, *Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6, February 2019. VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, focused on approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards." The OIG reviewed VISN facility physicians hired after January 1, 2018, to continue efforts to identify staff not meeting VHA employment requirements since "VHA officials told us [GAO] these types of reviews are not routinely conducted…[and] that the initial review was labor intensive."

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that veterans, their families, visitors, and employees in VHA healthcare facilities be provided a safe, clean, and functional environment of care in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[46] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[47] VHA also provides policy, mandatory procedures, and operational requirements for implementing an effective VHA supply chain management program at VA medical facilities, which includes VISN-level responsibility for oversight.[48]

The OIG inspection team reviewed relevant documents and interviewed VISN managers. Specifically, inspectors examined the following VISN-level requirements:

- Establishment of a policy that maintains a comprehensive environment of care (EOC) program at the VISN level
- Establishment of a VISN emergency management committee[49]
    - Met at least quarterly
    - Documented an annual review within the previous 12 months of the VISN's
        - Emergency Operations Plan
        - Continuity of Operations Plan
        - Hazards Vulnerability Analysis
    - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval
- Assessment of inventory management programs through a quality control review once per FY

[46] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016; VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[47] VHA Directive 1608.

[48] VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016. The directive was rescinded and replaced by VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[49] VHA Directive 0320.01.

Environment of Care Findings and Recommendations

The OIG found general compliance with the assessment of inventory management programs. However, the OIG identified deficiencies with the comprehensive EOC program policy and the VISN Emergency Management Committee.

VHA requires that the "VISN has a written policy that establishes and maintains a CEOC [comprehensive EOC] Program at the VISN level."[50] The OIG did not find evidence of a comprehensive EOC program policy. The lack of a written EOC policy could hinder compliance with VHA requirements and thorough oversight of facility EOC programs. The Network Safety Manager and Capital Assets Manager reported the belief that the Occupational Safety and Health, Environment, and Sanitation Program policy met the intent for an EOC policy since it references the "environment" and highlights program areas that, when grouped together, constitute the EOC program. The OIG found that the policy did not address the key elements of a comprehensive EOC program as established by VHA. The OIG also noted that the policy expired in 2014; the Network Safety Manager reported during the site visit that the policy was under review.

Recommendation 1

1. The Network Director evaluates and determines any additional reasons for noncompliance and ensures the development of a written policy that establishes and maintains a comprehensive environment of care program at the Veterans Integrated Service Network level.[51]

VISN concurred.

Target date for completion: Completed

VISN response: The Network Director's designee has reviewed and indicated there are no additional reasons for noncompliance. The required policy which establishes and maintains a comprehensive environment program has been developed, written, and published on January 8, 2021. The name of the policy is VISN 7 Comprehensive Environment of Care Program Policy.

VHA requires the VISN Emergency Management Committee to conduct annual reviews "of the VISN Office EOP [Emergency Operations Plan], Continuity of Operations Plan (COOP), and Hazards Vulnerability analysis (HVA)" and "the collective VISN-wide strengths, weaknesses, priorities and requirements for improvement that is documented in writing and sent to VISN

[50] VHA Directive 1608.

[51] The OIG reviewed evidence sufficient to demonstrate that the VISN had completed improvement actions and therefore closed the recommendation before publication of the report.

leadership for review and approval."[52] The OIG found the most recent reviews were completed in 2018 but did not find evidence of any subsequent completed annual reviews in 2019 or 2020. This insufficiency could prevent critical oversight of emergency management readiness. The Network Safety Manager reported being on leave at the time the 2019 reviews were due, and stated that the 2019 reviews were performed but associated reports had not been finalized, submitted to, or approved by the VISN Emergency Management Committee.

Recommendation 2

2. The Network Director evaluates and determines any additional reasons for noncompliance and ensures an annual review of the Emergency and Continuity of Operations Plans; Hazards Vulnerability Analysis; and collective Veterans Integrated Service Network-wide strengths, weaknesses, priorities, and requirements for improvement are submitted to executive leaders for review and approval.

VISN concurred.

Target date for completion: September 30, 2021

VISN response: The Network Director's designee has reviewed and indicated there are no additional reasons for noncompliance. The completed annual review of the Emergency and Continuity of Operations Plans; Hazards Vulnerability Analysis; and collective Veterans Integrated Service Network-wide strengths, weakness, priorities, and requirements for improvement was reviewed by executive leadership on the Healthcare Operations Committee (HOC) on November 18, 2020.

[52] VHA Directive 0320.01.

Medication Management: Long-Term Opioid Therapy for Pain

VHA has established pain management as a national priority. The VHA National Pain Management Strategy was initiated in November 1998, with its main objective being to "develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness."[53]

The VHA National Pain Management Program Office is responsible for policy development, coordination, oversight, and monitoring of the VHA National Pain Management Strategy. VHA requires VISNs to implement the Pain Management Strategy throughout VISN facilities. VHA also requires a VISN-level pain management point of contact to annually describe the progress in implementing the Pain Management Strategy to the VISN director and establish a VISN pain committee to develop timelines for achieving and maintaining pain management standards. In addition, VHA requires VISNs to have at least one Commission on Accreditation of Rehabilitation Facilities-accredited tertiary interdisciplinary pain care program.[54]

To determine whether the VISN complied with OIG-selected VHA requirements for pain management, the inspection team reviewed relevant documents and interviewed VISN managers on the following requirements:

- Appointment of a VISN-level pain management point of contact
- Annual reporting of the Pain Management Strategy implementation progress
- Establishment of a VISN-level pain committee
    - Monitoring of pain management standards
- Availability of a Commission on Accreditation of Rehabilitation Facilities-accredited tertiary interdisciplinary pain care program

Medication Management Findings and Recommendations

Generally, the VISN achieved the requirements listed above. The OIG made no recommendations.

[53] VHA Directive 2009-053, *Pain Management*, October 28, 2009.

[54] VHA Directive 2009-053. 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 [the Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs."

Women's Health: Comprehensive Care

Women represented 10.1 percent of the veteran population as of September 30, 2019.[55] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[56] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[57] Additionally, a 2016 VA report on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[58]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in all VA medical facilities.[59] VHA also requires that VISNs appoint a lead women veterans program manager (WVPM) to serve as the VISN representative on women veterans' issues and identify gaps through "VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN."[60]

To determine whether the VISN complied with OIG-selected VHA requirements to provide comprehensive healthcare services to women veterans, the inspection team reviewed relevant documents and interviewed selected managers on several VISN-level requirements:

- Appointment of a lead WVPM
- Establishment of a multidisciplinary team for comprehensive care
- Execution of interdisciplinary comprehensive strategic planning for women's health at the VISN level
- Provision of quarterly program updates to executive leaders

[55] "VETPOP2018 LIVING VETERANS BY AGE GROUP, GENDER, 2018-2048," Table 1L, National Center for Veterans Analysis and Statistics, accessed November 30, 2020, https://www.va.gov/vetdata/Veteran_Population.asp.

[56] "Veteran Population," National Center for Veterans Analysis and Statistics, accessed September 16, 2019. https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf.

[57] Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care, Final Report*, April 2015.

[58] Department of Veterans Affairs, Health Services Research & Development, Forum, *Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions*, Suicide Prevention, Spring 2018.

[59] VHA Directive 1330.01(4), *Health Care Services for Women Veterans,* February 15, 2017, amended January 8, 2021.

[60] VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018.

- Monthly calls held with facility WVPMs and women's health medical directors
- Completion of annual site visits
  - Needs assessment conducted
  - Progress towards implementation of recommended interventions tracked
- Assessments to identify staff education gaps
  - Development of educational program and/or resources when needs identified
- Availability of VISN-level support staff for implementing performance improvement projects
- Analysis of women veterans access and satisfaction data
  - Improvement actions implemented when recommended

Women's Health Findings and Recommendations

The VISN complied with requirements for the appointment of a lead WVPM, availability of VISN-level support staff, and analysis of women veterans access and satisfaction data. However, the OIG identified weakness with quarterly program updates, annual site visits, and educational gap assessments.

VHA requires that the lead WVPM provide program updates directly to the Network Director or CMO at least quarterly.[61] The OIG noted that the WVPM was hired in January 2019 and served as the Special Populations Program Manager. This position encompassed oversight of the Women's Health; Transition and Care Management; Intimate Partner Violence; Lesbian, Gay, Bisexual, and Transgender; and Traumatic Brain Injury programs.[62] However, the OIG found that the WVPM only presented women's health information during the VISN Operations meeting in August 2019, provided program updates to the CMO in November 2019, and presented women's health information to the Network Director in January 2020. A failure to provide consistent and routine updates could impede executive leaders from reallocating VISN resources to support the provision of comprehensive women veterans health care. The WVPM reported that the previous Network Director did not hold meetings for women's health updates, and meetings with the previous acting CMO did not include updates from the program managers. The WVPM also stated that there are plans to have more regular program updates under the current acting Network Director.

[61] VHA Directive 1330.01(4).

[62] The WVPM stated that until October 2019, responsibilities for the Special Populations Program Manager also included Caregiver Support.

Recommendation 3

3. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that the lead Women Veterans Program Manager provides quarterly program updates to executive leaders.

VISN concurred.

Target date for completion: September 30, 2021

VISN response: The Network Director's designee has reviewed and indicated there are no additional reasons for noncompliance. The Women Veterans Program Manager will provide quarterly program updates for executive leadership on Health Care Delivery Committee. Program updates will be scheduled quarterly as an agenda item.

VHA also requires the lead WVPM to conduct "yearly site visits at each facility within the VISN and additional site visits as needed."[63] The OIG did not find evidence of annual site visits. The WVPM reported that the last site visit under the previous WVPM occurred in June 2018 at the Carl Vinson VAMC and that the next site visit did not occur until January 2020 under the current WVPM. Failure to conduct yearly site visits could hinder the identification of facility concerns warranting VISN-level intervention. The WVPM reported not being oriented to the auditing process until the January 2020 site visit at the Tuscaloosa VAMC with the Deputy Field Director for VA's Central Office and the VISN Women's Health Medical Director. The WVPM also reported having a tentative FY 2020 site visit schedule.

Recommendation 4

4. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain the lead Women Veterans Program Manager completes annual site visits at each facility.

VISN concurred.

Target date for completion: September 30, 2021

VISN response: The Network Director's designee has reviewed and indicated there are no additional reasons for noncompliance. The Women Veterans Program manager will complete required annual site visits virtually. Virtual site visits will be scheduled monthly with summary reports and completed visits provided to and monitored by executive leaders of the Health Delivery Committee.

[63] VHA Directive 1330.02.

VHA mandates that the lead WVPM conduct "assessments to identify VA staff education gaps related to women's health" and develop or adapt "educational programs, materials, and resources where gaps are identified."[64] The OIG did not find evidence of educational gap assessments. A failure to address educational gaps could limit staff's ability to provide key women veterans services. The WVPM reported that facility staff self-identified learning needs, implemented programs locally, and received routinely forwarded information about training opportunities. The WVPM acknowledged that competing priorities and managing other assigned duties as the Special Populations Program Manager contributed to noncompliance.

Recommendation 5

5. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that the lead Women Veterans Program Manager completes assessments to identify staff education gaps related to women's health and develops or adapts educational programs, materials, and/or resources where gaps are identified.

VISN concurred.

Target date for completion: September 30, 2021

VISN response: The Network Director's designee has reviewed and indicated there are no additional reasons for noncompliance. An Education Needs Assessment was submitted as a survey to VISN 7 medical facilities. The results of the assessment were completed on August 13, 2020. The information gathered is being analyzed to develop/adapt educational programs and/or resources where gaps have been identified by the medical facilities. The analysis of the information and programs will be reported to and monitored by the Health Care Delivery Committee.

[64] VHA Directive 1330.02.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. The goal of Sterile Processing Services (SPS) is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[65]

VHA requires VISNs to appoint and maintain a VISN SPS management board charged with oversight of SPS and all reprocessing of critical and semi-critical RME at VISN facilities.[66] VHA also requires VISNs to conduct facility inspections using the RME Inspection Tool, provide the results for review by a VISN-level committee or board, and post the results to the RME SharePoint site within 30 days of the completed inspection. VISN SPS leads must ensure development of corrective action plans within 30 days of the completed inspections and track the action plans until all items are closed.[67]

The OIG examined relevant documents and interviewed key managers to determine the VISN's compliance with the following requirements:

- Establishment of a VISN SPS management board
- VISN-led RME inspection at each facility
  - Use of RME Inspection Tool
  - Documentation review of climate control
  - Reporting of inspection results to executive leaders
  - Posting of inspection results within the required time frame
  - Tracking of corrective action plans

High-Risk Processes Findings and Recommendations

The VISN complied with the requirements for a VISN SPS management board and VISN-led RME inspections. However, the OIG identified deficiencies with the posting of inspection results and oversight of facility corrective action plan development.

[65] Julie Jefferson, Martha Young. *APIC Text of Infection Control and Epidemiology*. Association for Professionals in Infection Control and Epidemiology, 2019. "Chapter 107: Sterile Processing."

[66] VHA Directive 1116(2), *Sterile Processing Services,* March 23, 2016.

[67] VHA Deputy Under Secretary for Health and Operations Management (DUSHOM) Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*, December 11, 2018.

VHA requires that inspection results be posted to the RME SharePoint site within 30 days of the VISN review.[68] The OIG did not find evidence that results for the Birmingham, Carl Vinson, Charlie Norwood, Tuscaloosa, or Wm. Jennings Bryan Dorn VAMCs or the Central Alabama Veterans HCS were posted within the required time frame. A failure to post results to the RME SharePoint site within 30 days could hinder timely execution of corrective measures to prevent untoward events. The VISN SPS Lead reported being aware of the requirement and stated that the timing of other site visits (including The Joint Commission) resulted in competing priorities.

Recommendation 6

6. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that Veterans Integrated Service Network-led facility reusable medical equipment inspection results are posted within the required time frame.

VISN concurred.

Target date for completion: September 30, 2021

VISN response: The Network Director's designee has reviewed and indicated there are no additional reasons for noncompliance. The VISN 7 SPS Lead will track and report timeliness of reports to SPS Subcommittee and ensure they are posted to the SPS SharePoint. Oversight for timely posting of inspections will be tracked and monitored via dashboard by the Quality, Safety and Value Committee.

Additionally, VHA requires VISN SPS leads to ensure development of facility corrective action plans within 30 days of the completed inspection and track action plans until all items are closed.[69] The OIG found that the VISN SPS Lead tracked corrective action plans until closure but did not ensure that action plans were developed within 30 days of the completed inspection. Lack of timely action plan development could hinder corrective measures to prevent untoward events. The VISN SPS Lead reported being aware of the requirement but did not realize that this applied at the VISN level as well.

Recommendation 7

7. The Network Director evaluates and determines additional reasons for noncompliance and ensures that facility corrective action plans are developed within the required time frame.

[68] *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*.
[69] *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*.

VISN concurred.

Target date for completion: September 30, 2021

VISN response: The Network Director's designee has reviewed and indicated there are no additional reasons for noncompliance. The VISN 7 SPS Lead will track and ensure timely development of action plans. The information will be reported to and tracked in the SPS Subcommittee. Oversight for timely action plans will be tracked and monitored via dashboard by the Quality, Safety and Value Committee.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for facility leaders to use these 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.

Healthcare Processes	Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinical vacancies • VISN efforts to reduce veteran suicides • Oversight inspections • VHA performance data • Observed trends in noncompliance	Seven OIG recommendations that can lead to patient and staff safety issues or adverse events are attributable to the Network Director. See details below.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Written utilization management plan • Annual utilization management program summary reviews • Collection, analysis, and action, as appropriate, in response to VISN peer review data • Quarterly VISN peer review data analysis reports submitted • Institutional disclosures for each facility reported quarterly	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Credentialing	• Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements • Regional Counsel or designee's documented review to determine if the physician meets appointment requirements • VISN CMO concurrence and approval of the Regional Counsel or designee's review	• None	• None
Environment of Care	• Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN emergency management committee • Assessment of inventory management programs through a quality control review once per FY	• None	• A written VISN-level comprehensive environment of care program policy is developed. • An annual review of the Emergency and Continuity of Operations Plans; Hazards Vulnerability Analysis; and collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement are submitted to executive leaders for review and approval.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Appointment of a pain management point of contact • Reporting of the Pain Management Strategy implementation progress • Establishment of a pain committee • Availability of an accredited tertiary interdisciplinary pain care program	• None	• None
Women's Health: Comprehensive Care	• Appointment of a lead women veterans program manager • Establishment of a multidisciplinary team for comprehensive care • Execution of interdisciplinary comprehensive strategic planning for women's health • Provision of quarterly program updates to executive leaders • Monthly calls held with facility women veterans program managers and women's health medical directors • Completion of annual site visits • Assessments to identify staff education gaps • Availability of VISN-level support staff for implementing performance improvement projects • Analysis of women veterans access and satisfaction data	• The lead Women Veterans Program Manager completes annual site visits at each facility.	• The lead Women Veterans Program Manager provides quarterly program updates to executive leaders. • The lead Women Veterans Program Manager conducts assessments to identify staff education gaps related to women's health and develops or adapts educational programs, materials, and resources where gaps are identified.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Reusable Medical Equipment	• Establishment of a VISN SPS management board • VISN-led facility RME inspections conducted	• None	• VISN-led facility RME inspection results are posted within the required time frame. • Facility corrective action plans are developed within the required time frame.

Appendix B: VISN 7 Profile

The table below provides general background information for VISN 7.

Table B.1. Profile for VISN 7
(October 1, 2016, through September 30, 2019)

Profile Element	VISN Data FY 2017*	VISN Data FY 2018†	VISN Data FY 2019‡
Total medical care budget	$3,631,128,764	$3,845,973,763	$3,936,751,989
Number of:			
• Unique patients	451,753	461,368	473,563
• Outpatient visits	5,958,131	6,129,825	6,254,187
• Unique employees	16,069	16,458	17,073
Type and number of operating beds:			
• Community living center	782	802	802
• Domiciliary	475	467	467
• Hospital	900	898	899
• Residential rehabilitation	47	47	47
Average daily census:			
• Community living center	556	562	564
• Domiciliary	333	341	365
• Hospital	572	561	548
• Residential rehabilitation	30	32	31

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, 2016, through September 30, 2017*
† October 1, 2017, through September 30, 2018
‡ October 1, 2018, through September 30, 2019

Appendix C: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 7 (October 1, 2018, through September 30, 2019)

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	VHA	68.3
		VISN 7	61.1
		Augusta, GA	61.8
		Birmingham, AL	58.9
		Charleston, SC	73.2
		Columbia, SC	66.6
		Decatur, GA	52.4
		Dublin, GA	69.3
		Montgomery/Tuskegee, AL	53.1
		Tuscaloosa, AL*	n/a
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.9
		VISN 7	81.1
		Augusta, GA	81.9
		Birmingham, AL	80.2
		Charleston, SC	85.0
		Columbia, SC	83.5
		Decatur, GA	78.7
		Dublin, GA	74.5
		Montgomery/Tuskegee, AL	68.4
		Tuscaloosa, AL	n/a

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	77.3
		VISN 7	71.4
		Augusta, GA	74.4
		Birmingham, AL	77.3
		Charleston, SC	82.1
		Columbia, SC	71.4
		Decatur, GA	64.6
		Dublin, GA	69.9
		Montgomery/Tuskegee, AL	59.5
		Tuscaloosa, AL	76.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	78.0
		VISN 7	72.0
		Augusta, GA	74.8
		Birmingham, AL	76.9
		Charleston, SC	78.5
		Columbia, SC	75.4
		Decatur, GA	65.7
		Dublin, GA	68.3
		Montgomery/Tuskegee, AL	64.0
		Tuscaloosa, AL	78.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 23, 2019)
n/a = Not applicable

** Tuscaloosa VAMC does not provide inpatient medical services; therefore, the score is marked not applicable.*

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Clinical Assessment Program Review of the Atlanta VA Medical Center, Decatur, Georgia, Report No. 16-00569-253, June 8, 2017	January 2017	0	21	–	0
Clinical Assessment Program Review of the Birmingham VA Medical Center, Birmingham, Alabama, Report No. 16-00581-239, June 1, 2017	February 2017	0	12	–	0
Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Health Care System, Decatur, Georgia, Report No. 17-02679-283, September 13, 2018	May 2017 October 2017	0	7	–	0
Comprehensive Healthcare Inspection Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama, Report No. 17-01851-72, February 6, 2018	June 2017	0	7	–	0
Comprehensive Healthcare Inspection Program Review of the Ralph H. Johnson VA Medical Center, Charleston, South Carolina, Report No. 18-00600-259, August 22, 2018	January 2018	0	4	–	0
Comprehensive Healthcare Inspection Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina, Report No. 18-00412-173, May 17, 2018	January 2018	0	8	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, *Georgia*, Report No. 19-00013-15, November 21, 2019	February 2019	0	24	–	22*
Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, *Georgia*, Report No. 18-04682-256, November 12, 2019	February 2019	0	22	–	22†
Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center, *Alabama*, Report No. 19-00057-238, September 27, 2019	April 2019	0	14	–	14‡

Source: Inspection/survey results verified with the Quality Management Health System Specialist on March 5, 2020

** As of February 2021, 3 of 24 recommendations issued to the medical center remained open (2, 5, and 6).*

† As of February 2021, 1 of 22 recommendations issued to the medical center remained open (16).

‡ As of February 2021, 1 of 14 recommendations issued to the medical center remained open (13).

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet InterQual criteria	A higher value is better than a lower value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Capacity	Percent increase in current physician and advanced practice provider capacity, based on productivity; capacity is not calculated for sites with above average productivity for their medical center group	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Cont stay reviews met	Percent acute continued stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value

Measure	Definition	Desired Direction
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value

Measure	Definition	Desired Direction
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix F: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Discharged to Community (SS)	Short-stay measure: percentage of short-stay residents who were successfully discharged to the community.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Outpatient ED visit (SS)	Short-stay measure: percent of short-stay residents who have had an outpatient emergency department (ED) visit.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.

Measure	Definition
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
Rehospitalized after NH Admission (SS)	Short-stay measure: percent of residents who were re-hospitalized after a nursing home admission.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

Source: VHA Support Service Center

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 28, 2021

From: Interim Director, VA Southeast Network(10N7)

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 7: VA Southeast Network, Duluth, GA

To: Director, Office of Healthcare Inspections (54CH04)

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

1. I have had the opportunity to review the Draft Report – Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 7, VA Southeast Network, Duluth, GA.
2. VISN 7 submits the attached status update providing justification and documentation to recommendations 1-7. I concur with the recommendations 1-7.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

Joe D. Battle
Interim Director, VA Southeast Network (10N7)

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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