DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont

CHIP REPORT | REPORT #21-00258-230 | SEPTEMBER 15, 2021

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Figure 1. *White River Junction VA Medical Center in Vermont.*
Source: https://vaww.va.gov/directory/guide/ (*accessed January 21, 2021*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
COVID-19	coronavirus disease
FY	fiscal year
OIG	Office of Inspector General
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the White River Junction VA Medical Center, which includes outpatient clinics in New Hampshire and Vermont. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

The OIG team looks at leadership and organizational risks, and at the time of the inspection, focused on the following additional areas:

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)[2]
5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
6. Care coordination (spotlighting inter-facility transfers)
7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual review of the White River Junction VA Medical Center during the week of January 25, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this

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

[2] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the White River Junction VA Medical Center because medical center staff did not administer remdesivir during the review period.

report may help this medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued two recommendations to the Medical Center Director. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the medical center's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. Organizational communications and accountability were managed through a committee reporting structure, with Executive Committee of the Governing Body oversight of several working groups. Leaders monitored patient safety and care through the Quality Safety & Value Board, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's leaders had worked together for over one year. The Associate Director for Patient Care Services, assigned in June 2010, was the most tenured leader. The Chief of Staff, assigned in November 2019, was the newest member of the leadership team.

Employee satisfaction survey results for the medical center demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected, but responses also pointed to opportunities for the Director and Chief of Staff to reduce employee feelings of moral distress at work.[3] Patient experience survey results indicated that patients appeared satisfied with the care provided.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[4]

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."

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

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

Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[5]

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

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions; the Systems Redesign and Improvement Program; and protected peer reviews. However, the OIG identified a deficiency in Surgical Work Group monthly meetings.

Care Coordination

The OIG observed general compliance with many of the expectations for inter-facility transfers. However, the OIG identified deficiencies in transmission of patients' advance directives to receiving facilities.

High-Risk Processes

The medical center met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with staff training.

Conclusion

The OIG conducted a detailed inspection across seven key areas (two administrative and five clinical) and subsequently issued two recommendations for improvement to the Medical Center Director. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use the recommendations to help guide improvements in operations and clinical care. The

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

recommendations address issues that may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes F and G, pages 48–49, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the White River Junction VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.[1]

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

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review, paused physical inspection steps (especially those involved in the environment of care-focused review topic), and initiated a COVID-19 pandemic readiness and response evaluation.

As such, to examine risks to patients and the organization, the OIG focused on core processes in the following areas of administrative and clinical operations (see figure 2):[4]

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[5]
3. Quality, safety, and value (QSV)
4. Registered nurse credentialing

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

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

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

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

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

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

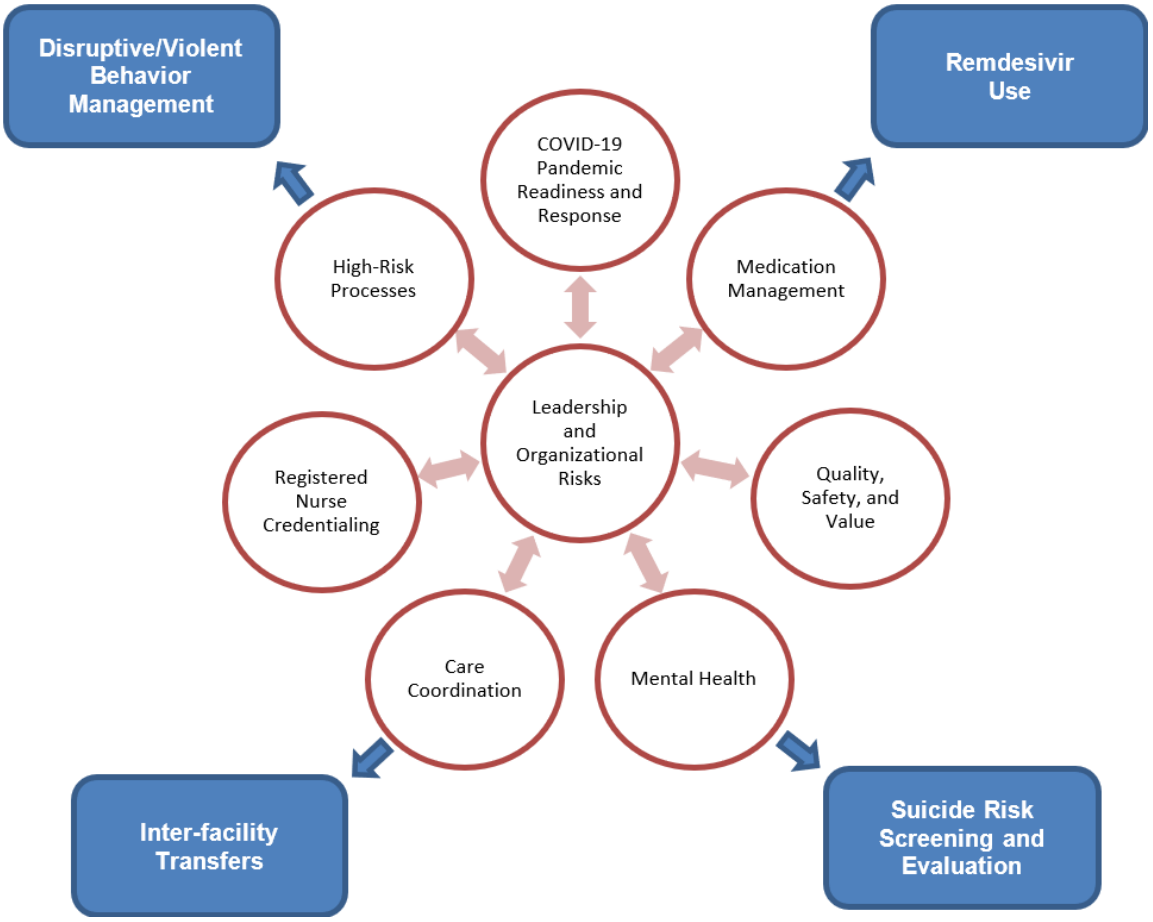


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

[6] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the White River Junction VA Medical Center because medical center staff did not administer remdesivir during the review period.

Methodology

The White River Junction VA Medical Center also provides care through outpatient clinics in New Hampshire and Vermont. Additional details about the types of care provided by the medical center can be found in appendixes B and C.

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality and clinical functions, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[7] The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from December 10, 2016, through January 29, 2021, the last day of the unannounced multiday evaluation.[8] During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[9] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the medical center completes corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that medical center leaders developed based on the reasons for noncompliance.

The OIG conducted the inspection in accordance with OIG procedures and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

[7] The OIG did not review VHA's internal survey results and instead focused on OIG inspections and external surveys that affect facility accreditation status.

[8] The range represents the time period from the prior Clinical Assessment Program site visit to the completion of the unannounced, multiday virtual CHIP visit in January 2021.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA medical center. Leadership and organizational risks can affect a medical center's ability to provide care in the clinical focus areas.[10] To assess this medical center's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the medical center response
8. VHA performance data (medical center)

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this medical center's reported organizational structure. The medical center had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

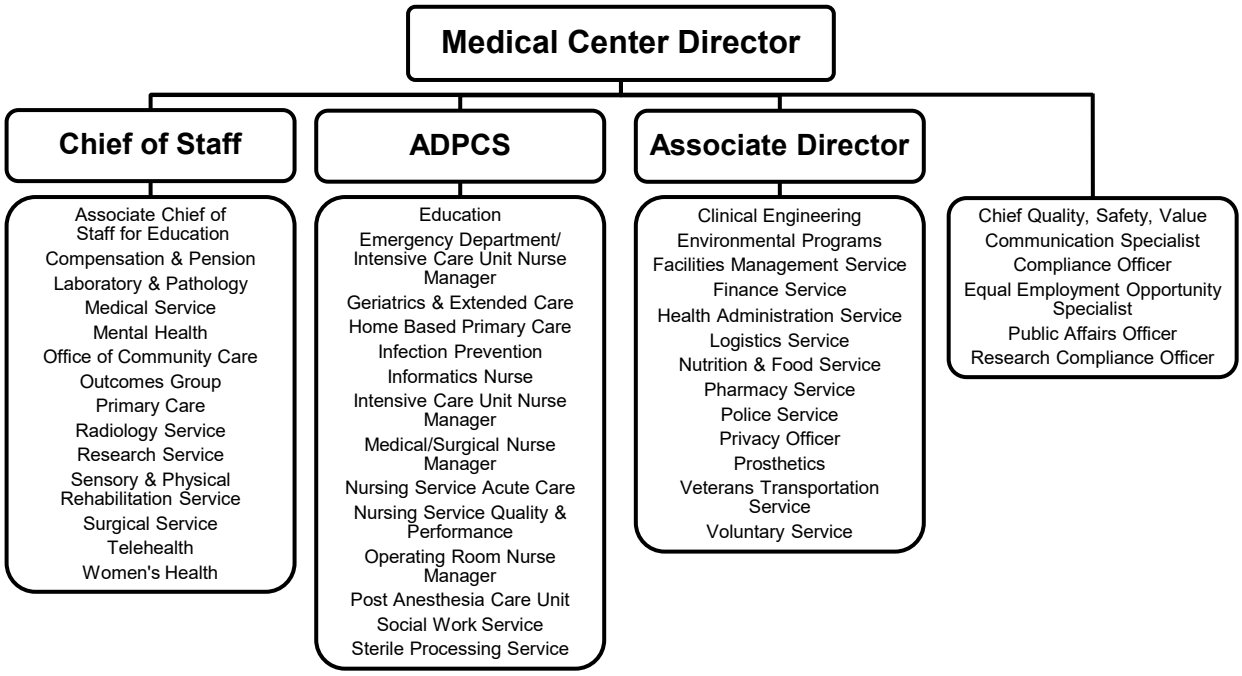


Figure 3. *VA medical center organizational chart.*
Source: White River Junction VA Medical Center (received January 27, 2021).

At the time of the OIG inspection, the executive team had worked together for over one year. The ADPCS, assigned in June 2010, was the most tenured leader, and the Chief of Staff, assigned in November 2019, was the newest member of the leadership team (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	April 28, 2019
Chief of Staff	November 24, 2019
Associate Director for Patient Care Services	June 6, 2010
Associate Director	August 5, 2018

Source: White River Junction VA Medical Center acting Senior Strategic Business Partner (received January 25, 2021).[11]

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

[11] "Senior Strategic Business Partner" is VHA's new organizational title for Chief of Human Resources.

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, the executive leadership team members were able to speak 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 Director served as the chairperson of the Executive Committee of the Governing Body, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Committee of the Governing Body oversaw various working groups such as the Clinical Executive, Nurse Executive, Administrative Executive, and Workforce Executive Boards.

Medical center leaders monitored patient safety and care through the Quality Safety & Value Board, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Committee of the Governing Body (see figure 4).

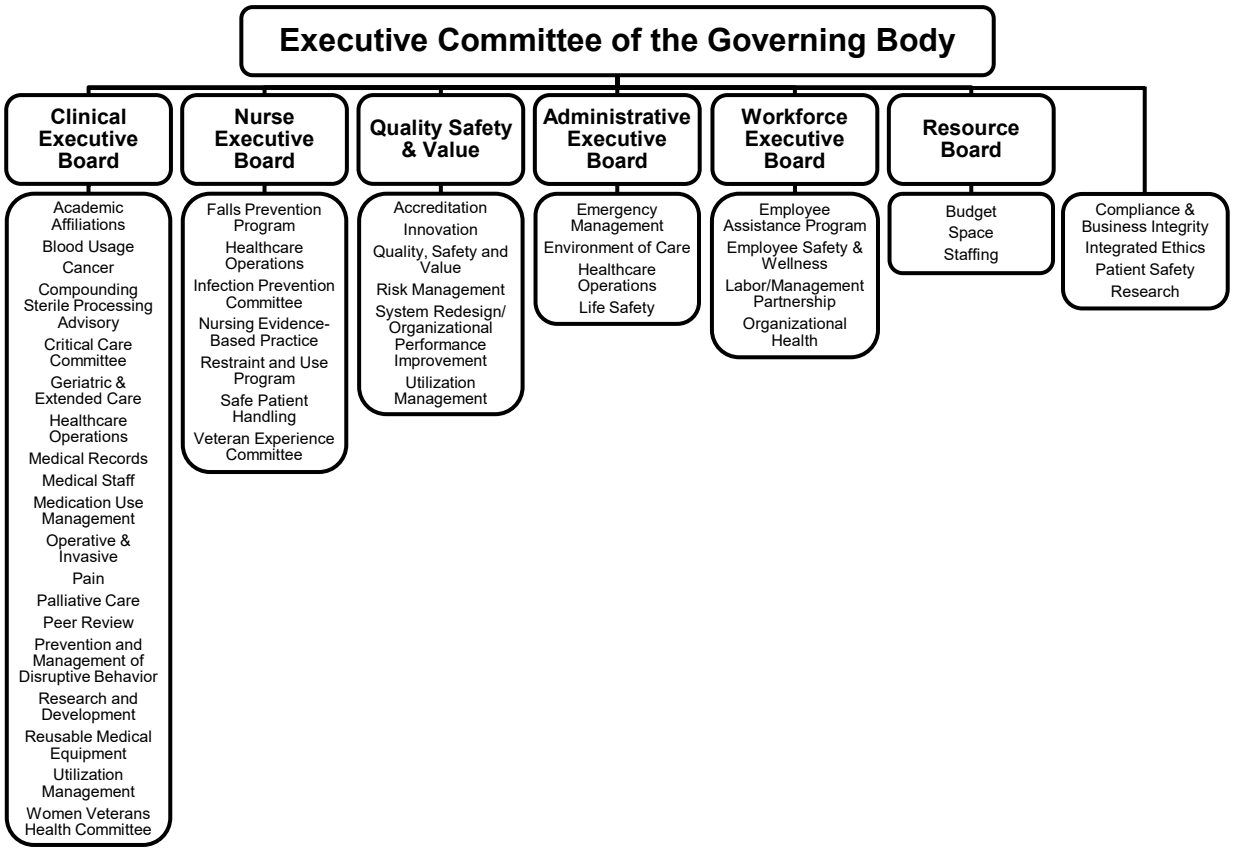


Figure 4. *VA medical center committee reporting structure.*

Source: White River Junction VA Medical Center (received January 28, 2021).

Budget and Operations

The medical center's FY 2020 annual medical care budget of $325,133,611 increased almost 33 percent compared to the previous year's budget of $244,507,222.[12] When asked about the effect of this change on the medical center's operations, the Director reported that drug costs are high and community care costs have doubled since implementation of the MISSION Act—a problem unique to VA.[13]

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[14] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[15] In addition, the OIG has demonstrated a link between staffing shortages and negative effects on patient care delivery.[16]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[17] The executive leaders confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection. The Chief of Staff reported the implementation of strategies to address the primary care physician shortage; this included hiring family physicians and increasing the utilization of advanced practice registered nurses and physician assistants. The Chief of Staff also reported that current primary care staffing was sufficient to meet patient care needs; however, to ensure timely access to specialty care, the medical center used telemedicine to connect providers with patients who needed appointments right away.

[12] VHA Support Service Center.

[13] "MISSION Act Strengthens VA Care," Department of Veterans Affairs, accessed April 12, 2021, https://missionact.va.gov/. The Maintaining Internal System and Strengthening Integrated Outside Network (MISSION) Act of 2018 gives Veterans "greater access to health care in VA facilities and the community, expands benefits for caregivers, and improves VA's ability to recruit and retain the best medical providers."

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

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

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

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

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Nurse	1. General Engineering
2. Primary Care	2. Air Conditioning Equipment Mechanic
3. Hematology/Oncology	3. Management and Program Analysis
4. Neurology	4. Medical Supply Aide and Technician
5. RN Staff–Emergency Dept/Urgent Care	5. Custodial Worker

Source: VA OIG.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[18] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[19] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center average was similar to the VHA average.[20] However, the leaders' scores were consistently higher than those for VHA and the medical center.

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

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

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

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.5	74.9	78.6	78.0	97.5	87.3
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	4.0	3.7	4.5	3.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.7	4.4	3.9	4.4	4.1
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	4.0	3.9	4.4	4.1

Source: VA All Employee Survey (accessed December 21, 2020).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[21] The medical center average for the selected survey questions was similar to the VHA average. The ADPCS and Associate Director scores were consistently better than those for VHA and the medical center. However, opportunities appeared to exist for the Director and

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

Chief of Staff to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.4	4.2	4.9	4.6
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	3.8	4.0	4.1	4.8	4.2
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)	1.4	1.4	1.6	1.6	0.9	0.7

Source: VA All Employee Survey (accessed December 21, 2020).

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment." To this end, leaders initiated the "End Harassment" and "Stand Up to Stop

Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[22]

The Director reported implementing strategies from VA's "Stand Up to Stop Harassment Now!" campaign.[23] Further, the Director stated there is no tolerance for any harassment or discrimination. To demonstrate commitment to a culture of safety, the Chief of Staff reported that the entire leadership team signed the "Stand Up to Stop Harassment Now!" campaign declaration. A poster of the signed declaration was created and displayed at the medical center.

Table 5 summarizes employee perceptions of respect and discrimination based on VHA's All Employee Survey responses. The medical center and executive leadership team averages were similar to or better than the VHA average. Leaders appeared to maintain an environment where staff felt respected and safe and discrimination was not tolerated.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.1	4.1	4.6	4.3
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.0	4.2	4.5	4.4	4.8	4.4
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.1	3.9	5.0	4.4

Source: VA All Employee Survey (accessed December 21, 2020).

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

[23] Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*.

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through September 30, 2020. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and support benchmarking its performance against the private sector.

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the White River Junction VA Medical Center.[24] For this medical center, the overall patient satisfaction survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	White River Junction Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	83.2
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	89.1
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	92.5

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

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[25] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). The results for male and female respondents were more favorable than the corresponding VHA averages. System leaders appeared to be actively engaged with male and female patients (for example, by engaging veterans through community activities, ensuring a private entrance for veterans in the comprehensive women's health program, and the Director actively participating on the Women Veterans Advisory Council).

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

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	82.4	100
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	89.2	89.1
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	89.3	94.5

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

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

The medical center averages are based on 405–408 male and 20 female respondents, depending on the question.

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

Table 8. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	65.0	76.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	67.2	70.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	79.8	87.8

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

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

The medical center averages are based on 479–1,351 male and 34–85 female respondents, depending on the question.

Table 9. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	69.6	62.0
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	70.6	96.4
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	86.2	82.9

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 30, 2020).

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

The medical center averages are based on 350–989 male and 18–46 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

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

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

The Joint Commission (TJC).[27] At the time of the OIG review, the medical center had closed all recommendations for improvement issued since the previous OIG Clinical Assessment Program site visit conducted in December 2016.

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[28]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Clinical Assessment Program Review of the White River Junction VA Medical Center, White River Junction, Vermont*, Report No. 16-00556-244, June 20, 2017)	December 2016	24	0
TJC Hospital Accreditation	February 2018	25	0
TJC Behavioral Health Care Accreditation		6	0
TJC Home Care Accreditation		3	0

Source: OIG and TJC (inspection/survey results received from Clinical Analyst on January 25, 2021).

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

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

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

[28] VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment "is supported through a system-wide, long-term joint collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs." "About the College of American Pathologists," College of American Pathologists, accessed February 20, 2019, https://www.cap.org/about-the-cap. According to the College of American Pathologists, for 75 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." Additionally, as stated in VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

Table 11 lists the reported patient safety events from December 10, 2016 (the prior OIG Clinical Assessment Program site visit), through January 25, 2021.[29]

Table 11. Summary of Selected Organizational Risk Factors (December 10, 2016, through January 25, 2021)

Factor	Number of Occurrences
Sentinel Events	4
Institutional Disclosures	5
Large-Scale Disclosures	0

Source: White River Junction VA Medical Center's Patient Safety Manager and Risk Manager (received January 27, 2021).

The Director spoke knowledgeably about serious adverse event reporting. Adverse and sentinel events are reported through both the chain of command and incident reporting system. Additionally, the Patient Safety Manager reports events to leaders through the Quality Safety & Value Board. Institutional disclosure determinations are decided on case-by-case assessments. They follow the process of a governance review, and the Chief of Staff, with the Director's concurrence, determines if an institutional disclosure needs to occur. Further, the medical center's process for serious event follow-up includes quarterly patient safety reports to the Quality Safety & Value Board about investigation status and action implementation and closure.

[29] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The White River Junction VA Medical Center is a medium complexity (2) affiliated system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

Veterans Health Administration Performance Data for the Medical Center

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[30]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the White River Junction VA Medical Center's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of mental health (MH) continuity (of) care, rating (of) primary care (PC) provider, care transition, and rating (of) specialty care (SC) provider). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, health care associated (HC assoc) infections; adjusted length of stay (LOS); and Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient behavioral health screening, prevention, immunization, and tobacco (HEDIS Like – HED90_ec)).[31]

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

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

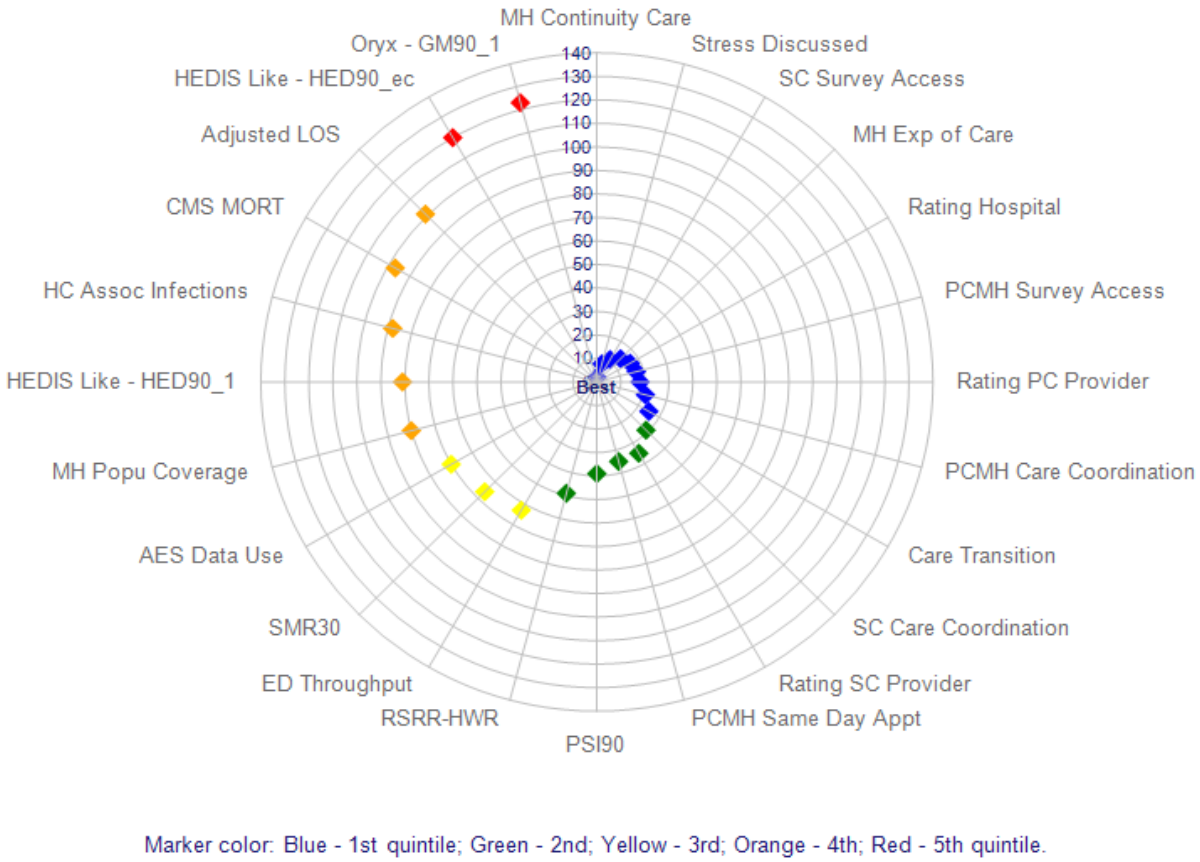


Figure 5. *Medical center quality of care and efficiency metric rankings for FY 2020 quarter 3 (as of June 30, 2020).*

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

The medical center's executive leadership team had worked together for over one year at the time of the virtual review. The ADPCS, assigned in June 2010, was the most tenured leader, and the Chief of Staff, assigned November 2019, was the newest member of the leadership team. The executive leaders confirmed the top clinical and nonclinical shortages at the time of the OIG inspection, and the Chief of Staff discussed strategies taken to address the shortages.

Selected employee satisfaction survey responses demonstrated satisfaction with leadership and maintenance of an environment where staff felt respected, but responses also pointed to opportunities for the Director and Chief of Staff to reduce employee feelings of moral distress at work. Patient experience survey data indicated satisfaction with the care provided, and selected survey results for male and female respondents were consistently more favorable than those for male and female VHA patients nationally. The OIG's review of the medical center's

accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. Executive leaders were knowledgeable within their scope of responsibilities about selected VHA SAIL data and should continue efforts to sustain and further improve medical center performance.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[32] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[33]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[34] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[35]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's effect on the medical center and its leaders' subsequent responses. The OIG analyzed performance in the following domains:

- Emergency preparedness
- Supplies, equipment, and infrastructure
- Staffing
- Access to care

The OIG also surveyed medical center staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up.

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

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

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

[34] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[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] 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 VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center's committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization." Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[39] The OIG team examined various requirements related to systems redesign and improvement:

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

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

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[40] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[41] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[42] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[43]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[44]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

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

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

[41] VHA Directive 1190.

[42] VHA Directive 1190.

[43] VHA Directive 1190.

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[45] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[46]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[47]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions, the Systems Redesign and Improvement Program, and protected peer reviews. However, the OIG identified weaknesses in Surgical Work Group meetings.

VHA requires medical facility directors to ensure that facilities with surgery programs have a surgical work group that meets at least monthly.[48] The OIG reviewed Surgical Work Group meeting minutes from January 17, 2020, through January 21, 2021, and found that the group did not meet monthly.[49] Three meetings were cancelled (February, April, and December 2020), which resulted in a lack of review and analysis of surgery program data during those months. The Chief, Surgical Services reported being unaware of the monthly Surgical Work Group meeting requirement.

[45] "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, https://vaww.nso.med.va.gov/apps/VASQIP/Pages/Default.aspx. (This is an internal VA website not publicly accessible.)

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

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

[48] VHA Directive 1102.01(1).

[49] The Surgical Work Group is a subcommittee of the Operative and Invasive committee.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that the Surgical Work Group meets monthly.

Medical center concurred.

Target date for completion: January 31, 2022

Medical center response: The facility confirmed the Surgical Work Group did not meet monthly in 2020 for the following reasons: April 2020 meeting was cancelled due to COVID 19 response, December 2020 meeting was cancelled due to a significant snowstorm. The Surgical Workgroup has been meeting monthly since January 2021 and all core members, Chief of Surgery, Chief of Staff, Surgical Quality Nurse and Operating Room Manager, were present. As per VHA National Surgery Office requirements meetings will continue monthly, if a core member cannot attend, a delegate will be appointed. Data will be reported monthly to the Clinical Executive Board until 100% meeting compliance is sustained for six additional months.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[50] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[51]

VA requires all RNs to hold at least one active, unencumbered license.[52] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[53] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[54] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[55]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 29 RNs hired from January 1 through December 20, 2020. The OIG determined whether

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

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

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

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

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

[53] 38 U.S.C. § 7402.

[54] VHA Directive 2012-030.

[55] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[56] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[57] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[58]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and completion of the Comprehensive Suicide Risk Assessment when screening is positive.[59] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[60] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

- Completion of suicide safety plans by required staff
- Completion of mandatory training by staff who develop suicide safety plans

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

- relevant documents;

[56] "Preventing Suicide," Centers for Disease Control and Prevention, accessed December 9, 2020, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

[57] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.

[58] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.

[59] Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018.

[60] DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

- the electronic health records of 48 randomly selected patients who were seen in the emergency department/urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[61]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients." Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[62]

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

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

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 45 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with many of the expectations for inter-facility transfers. However, the OIG identified deficiencies in transmission of patients' advance directives to receiving facilities.

VHA requires that staff "send all pertinent medical records available, including an active patient medication list and any medications given to the patient prior to transfer with the patient, and documentation of the patient's advance directive made prior to transfer, if any."[63] Twelve of 45 electronic health records contained evidence of an advanced directive. However, the OIG

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

estimated that none of the applicable records had evidence that staff sent the advance directive to the receiving facility. As a result, receiving facility staff did not have patients' healthcare preferences available on admission. The Associate Chief of Nursing, Quality and Performance reported that medical center staff inadvertently omitted the advance directive question when they modified the national inter-facility transfer template to create a local version. Due to the low number of patients identified for the advance directive requirement, the OIG made no recommendation.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[64] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[65] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[66]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[67]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[68]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[69]

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

[65] VHA Directive 2012-026.

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

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

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

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[70] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[71] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The medical center addressed many of the indicators of expected performance. However, the OIG noted opportunities for improvement related to completion of the required prevention and management of disruptive behavior trainings.

VHA requires employees to "complete initial training of all assigned PMDB [Prevention and Management of Disruptive Behavior] courses within 90 days of hire."[72] The OIG reviewed the training records of 30 employees and found that none of the employees whose workplace was deemed low or moderate risk completed part 2 of the training. The OIG also found that none of the employees whose workplace was deemed high risk completed parts 2 and 3 of the training. This could result in employees' lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Chair of the Prevention and Management of Disruptive Behavior Committee stated that parts 2 and 3 of the training were suspended due to COVID-19. The chair reported following executive leaders' guidance to cease the hands-on training to prevent employee exposure to COVID-19. This is a repeat finding from the previous Clinical Assessment Program review.

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

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

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

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[73]

Medical center concurred.

Target date for completion: July 23, 2022

Medical center response: Employees were found to be deficient in their Prevention and Management of Disruptive Behavior (PMDB) part 2 and 3 trainings because classes were suspended due to COVID-19. Medical Center Policy change in 2019 significantly increased the number of people who are required to complete part 2, and the execution of their training plan was disrupted by the COVID moratorium on training. Other reasons for deficiency include a shortage of certified PMDB trainers and restricted class size of 8 participants when classes initially resumed. Eight staff members have been identified to be trained as PMDB trainers the week of July 26, 2021. Upon completion of the training program, the increased number of trainers will allow PMDB part 2 classes to be scheduled more frequently and recent changes in COVID restrictions allow for 16 participants per class. The increase in the number of trainers will also allow part 3 trainings to resume.

The PMDB Facility Coordinator will work closely with the education department to prioritize the training for new employees to ensure that training is completed within 90 days for new employees. On-site training will be provided to employees working at the Community Based Outpatient Clinics. Data will be reported monthly to the Disruptive Behavior Committee and quarterly to the Clinical Executive Board. Monitoring will continue until 90 percent of required employees have received their PMDB part 2 and part 3 training.

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

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. medical system. To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed review of seven clinical and administrative areas and provided two recommendations on issues that may adversely affect patients. While the OIG's recommendations are not a comprehensive assessment of the caliber of services delivered at this medical center, they illuminate areas of concern and guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines two OIG recommendations for improvement of noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director. The intent is for the leader to use these recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Budget and operations • Staffing • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Identified factors related to possible lapses in care and medical center response • VHA performance data (medical center)	• None	• None
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • Staff feedback	The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• None	• The Surgical Work Group meets monthly.

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• Employees complete all required prevention and management of disruptive behavior training.

Appendix B: Medical Center Profile

The table below provides general background information for this medium complexity (2) affiliated medical center reporting to VISN 1.[1]

Table B.1. Profile for White River Junction VA Medical Center (405) (October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019	Medical Center Data FY 2020‡
Total medical care budget	$234,836,227	$244,507,222	$325,133,611
Number of:			
• Unique patients	25,830	25,478	24,182
• Outpatient visits	284,707	288,309	271,062
• Unique employees§	966	1,036	1,037
Type and number of operating beds:			
• Domiciliary	14	14	14
• Intermediate	7	7	7
• Medicine	34	34	34
• Mental health	12	12	12
• Surgery	9	9	9
Average daily census:			
• Community living center	–	4	8
• Domiciliary	12	12	6
• Medicine	18	20	17
• Mental health	8	9	5

[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) An affiliated medical center is associated with a medical residency program. VHA medical centers are classified according to a facility complexity model; a designation of "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs."

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019	Medical Center Data FY 2020‡
• Surgery	5	5	3

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

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

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

October 1, 2018, through September 30, 2019.

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

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

Appendix C: VA Outpatient Clinic Profiles

The VA outpatient clinics in communities within the catchment area of the medical center provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table C.1. provides information relative to each of the clinics.[1]

Table C.1. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2019, through September 30, 2020)

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Bennington, VT	405GA	3,099	1,795	Cardiology Dermatology Endocrinology Podiatry Urology	–	Nutrition Weight management
Brattleboro, VT	405GC	2,252	635	Anesthesia Cardiology Dermatology Endocrinology Podiatry Urology	–	Nutrition Pharmacy Weight management

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Burlington, VT	405HA	7,147	4,926	Anesthesia Cardiology Endocrinology Eye Gastroenterology Nephrology Orthopedics Podiatry Pulmonary/ Respiratory disease Rheumatology Urology	EKG	Nutrition Pharmacy Weight management
Littleton, NH	405HC	3,593	1,776	Anesthesia Cardiology Dermatology Endocrinology Podiatry Urology	–	Nutrition Pharmacy Weight management
Keene, NH	405HE	1,608	690	Cardiology Dermatology Endocrinology Podiatry Urology	–	Nutrition Pharmacy Weight management

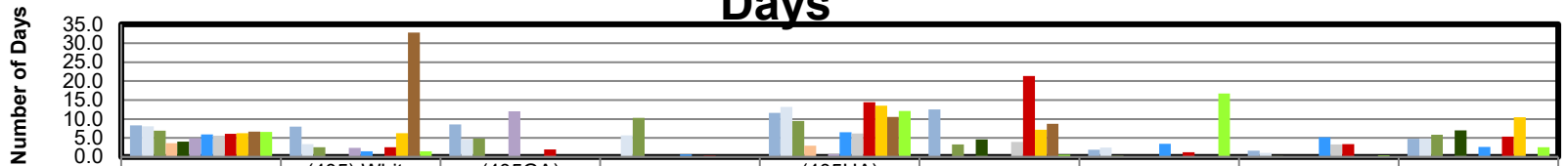
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Rutland, VT	405HF	2,707	1,362	Cardiology Dermatology Endocrinology Podiatry Urology	–	Nutrition Pharmacy Weight management
Newport, VT	405QB	1,765	518	Cardiology Dermatology Endocrinology Podiatry Urology	–	Nutrition Pharmacy Weight management

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days



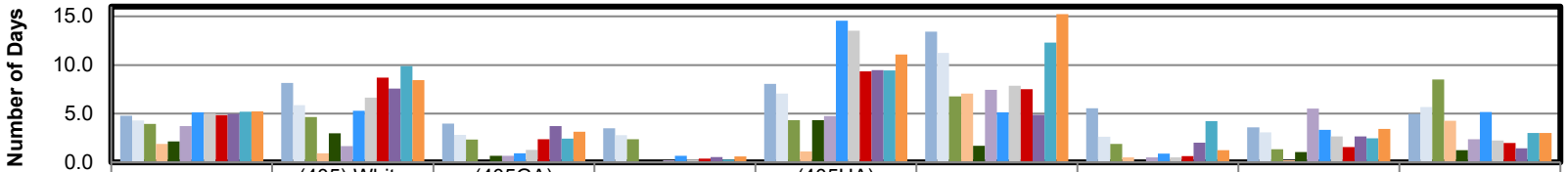
	VHA All	(405) White River Junction, VT	(405GA) Bennington, VT	(405GC) Brattleboro, VT	(405HA) Burlington Lakeside, VT	(405HC) Littleton, NH	(405HE) Keene, NH	(405HF) Rutland, VT	(405QB) Newport, VT
JAN-FY19	8.3	8.0	8.6	0.0	11.6	12.5	1.9	1.6	4.8
FEB-FY19	8.1	3.4	4.5	5.7	13.2	0.0	2.5	1.1	4.9
MAR-FY19	6.9	2.5	4.9	10.3	9.5	3.3	0.3	0.3	5.9
APR-FY19	3.6	0.0	0.0	n/a	3.0	0.0	0.0	n/a	0.0
MAY-FY19	4.0	0.2	0.0	0.0	0.2	4.6	n/a	0.0	7.0
JUN-FY19	4.9	2.4	12.0	0.0	0.7	0.0	n/a	0.0	0.0
JUL-FY19	5.9	1.5	0.0	0.7	6.5	0.0	3.5	5.2	2.7
AUG-FY19	5.6	0.0	0.0	0.0	6.2	4.0	0.0	3.3	0.0
SEP-FY19	6.1	2.5	2.0	0.3	14.4	21.3	1.3	3.4	5.3
OCT-FY20	6.3	6.2	0.0	0.0	13.5	7.2	0.0	0.0	10.5
NOV-FY20	6.7	32.8	0.0	0.0	10.6	8.8	n/a	0.0	n/a
DEC-FY20	6.6	1.5	0.0	0.0	12.1	0.6	16.7	0.4	2.6

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the medical center's explanation for the increased wait times for White River Junction.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA All	(405) White River Junction, VT	(405GA) Bennington, VT	(405GC) Brattleboro, VT	(405HA) Burlington Lakeside, VT	(405HC) Littleton, NH	(405HE) Keene, NH	(405HF) Rutland, VT	(405QB) Newport, VT
JAN-FY20	4.8	8.1	4.0	3.5	8.1	13.4	5.6	3.6	5.0
FEB-FY20	4.3	5.9	2.8	2.8	7.1	11.2	2.6	3.1	5.7
MAR-FY20	3.9	4.7	2.3	2.4	4.3	6.8	1.9	1.3	8.5
APR-FY20	1.9	0.9	0.0	0.0	1.1	7.1	0.5	0.2	4.3
MAY-FY20	2.1	3.0	0.7	0.1	4.3	1.7	0.1	1.0	1.3
JUN-FY20	3.7	1.7	0.7	0.2	4.7	7.4	0.5	5.5	2.4
JUL-FY20	5.1	5.3	0.9	0.7	14.6	5.1	0.9	3.3	5.2
AUG-FY20	5.0	6.6	1.3	0.3	13.5	7.9	0.5	2.7	2.2
SEP-FY20	4.9	8.7	2.4	0.4	9.3	7.5	0.7	1.6	2.0
OCT-FY21	5.0	7.6	3.7	0.5	9.5	4.9	2.0	2.7	1.4
NOV-FY21	5.2	9.9	2.4	0.3	9.5	12.3	4.2	2.5	3.0
DEC-FY21	5.2	8.5	3.1	0.6	11.1	15.2	1.2	3.4	3.0

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

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

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

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES Data Use	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
Care transition	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like – HED90_1	Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient behavioral health screening, prevention, immunization, and tobacco	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS composite score related to outpatient care for diabetes and ischemic heart disease	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
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 – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating 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
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
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 29, 2021

From: Director, VISN 1 VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont

To: Director, Office of Healthcare Inspections (54CH02)

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

1. I have reviewed and concur with the response for the draft report of the Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont.

2. I have reviewed the Healthcare System Director's action plan and projected completion dates. I concur with the plan and have complete confidence that the plan will be effective. VISN 1 will assist the Healthcare System's leadership in reaching full compliance in a timely manner.

3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Ryan Lilly, MPA

Appendix G: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: July 29, 2021

From: Director, White River Junction VA Medical Center (405/00)

Subj: Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont

To: Director, VISN 1 VA New England Healthcare System (10N1)

Thank you for the opportunity to respond to the Comprehensive Healthcare Inspection of the White River Junction VA Medical Center.

I have reviewed and concur with the recommendations in this report. The facility has addressed all recommendations. Corrective action plans are submitted in the attached report.

(Original signed by:)

Brett Rusch, MD

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Frank Keslof, MHA, EMT, Team Leader Sheila Cooley, MSN, GNP Miquita Hill-McCree, MSN, RN Sheeba Keneth, MSN/CNL, RN Thea Sullivan, MBA, RN Sandra Vassell, MBA, RN
Other Contributors	Elizabeth Bullock Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH, BS Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA April Jackson, MHA Scott McGrath, BS Larry Ross, Jr., MS Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH, BS Robert Wallace, ScD, MPH

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