DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, Florida

CHIP REPORT | REPORT #21-00274-289 | OCTOBER 13, 2021

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Figure 1. *James A. Haley Veterans' Hospital in Tampa, Florida.*
Source: *https://va.gov/directory/guide* (*accessed March 16, 2021*).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the James A. Haley Veterans' Hospital, which includes multiple outpatient clinics in Florida. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

The OIG conducted an unannounced virtual review of the James A. Haley Veterans' Hospital during the week of March 22, 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 hospital'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 report may help this hospital and other Veterans Health Administration (VHA) facilities identify

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

vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued three recommendations to the Director, Chief of Staff, and Associate Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the hospital's leadership team consisted of the Director, Deputy Director, Chief of Staff, Associate Director for Patient Care Services, Associate Director, and Assistant Director. The hospital managed organizational communications and accountability through a committee reporting structure, with the Governance Board overseeing several working groups. Leaders monitored patient safety and care through the Quality Safety Value Board, which tracked and trended quality of care and patient outcomes.

When the OIG conducted this inspection, the executive team had worked together for approximately six months. The director, deputy director, and associate director positions were filled in an acting capacity. The Associate Director for Patient Care Services, assigned in April 2010, was the most tenured leader. The acting Associate Director was the newest member of the leadership team, assigned in October 2020.

The OIG reviewed employee satisfaction survey results, which highlighted opportunities for the Associate Director for Patient Care Services and Associate Director to adopt servant leadership traits. Selected patient experience survey scores were generally similar to or more favorable than the corresponding VHA averages; however, opportunities appeared to exist for leaders to improve access to urgently needed outpatient appointments.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events. The OIG identified an organizational risk factor related to patient falls.

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."[2] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one

[2] "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.)

way to understand the similarities and differences between the top and bottom performers within VHA.[3]

The Director, Chief of Staff, and Associate Director for Patient Care Services were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and Community Living Center SAIL models.[4] In individual interviews, these three leaders were also 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 hospital 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 hospital 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 significant weakness with the Surgical Workgroup's processes.

Medication Management

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

Care Coordination

The OIG observed general compliance with many of the expectations for inter-facility transfers. However, the OIG found a deficiency with transfer documentation.

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[3] "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.)

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

High-Risk Processes

The hospital met some of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with Disruptive Behavior Committee participation and staff training.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued three recommendations for improvement to the Director, Chief of Staff, and Associate Director for Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this hospital. The intent is for hospital leaders to use these recommendations to help guide improvements in operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Hospital Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 57–58, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the James A. Haley Veterans' Hospital and related outpatient clinics examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and hospital 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 eight areas of administrative and clinical operations (see figure 2):[4]

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[5]
3. Quality, safety, and value (QSV)
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. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
7. Care coordination (spotlighting inter-facility transfers)
8. High-risk processes (examining the management of disruptive and violent behavior)

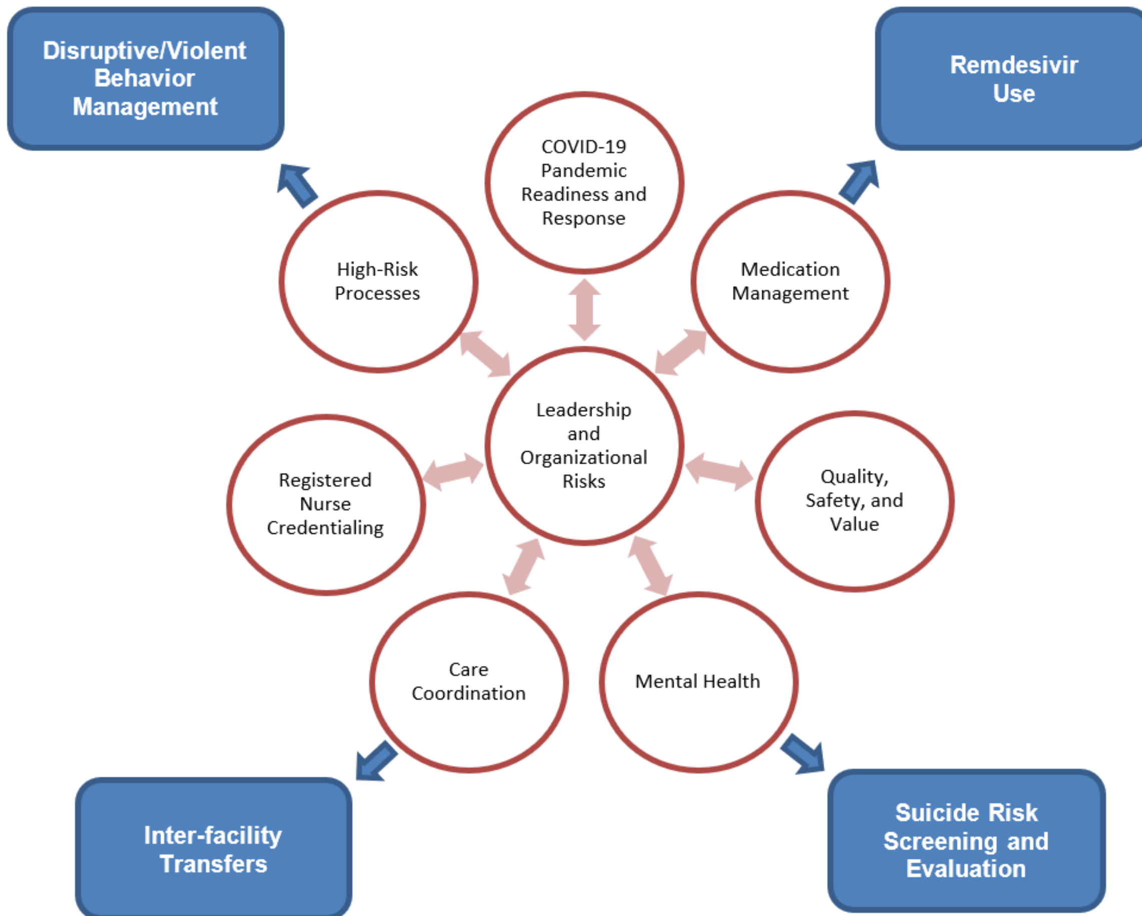

Figure 2*. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

The James A. Haley Veterans' Hospital also provides care through multiple outpatient clinics in Florida. Additional details about the types of care provided by the hospital can be found in appendixes B and C.

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality and clinical functions, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[6] The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from February 9, 2019, through March 26, 2021, the last day of the unannounced multiday evaluation.[7] 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 hospital and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[8] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the hospital completes corrective actions. The Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that hospital 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.

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

[7] The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in March 2021.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect a healthcare system's ability to provide care in the clinical focus areas.[9] To assess this hospital'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 hospital response
8. VHA performance data (hospital)
9. VHA performance data (community living center (CLC))[10]

Executive Leadership Position Stability and Engagement

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

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

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

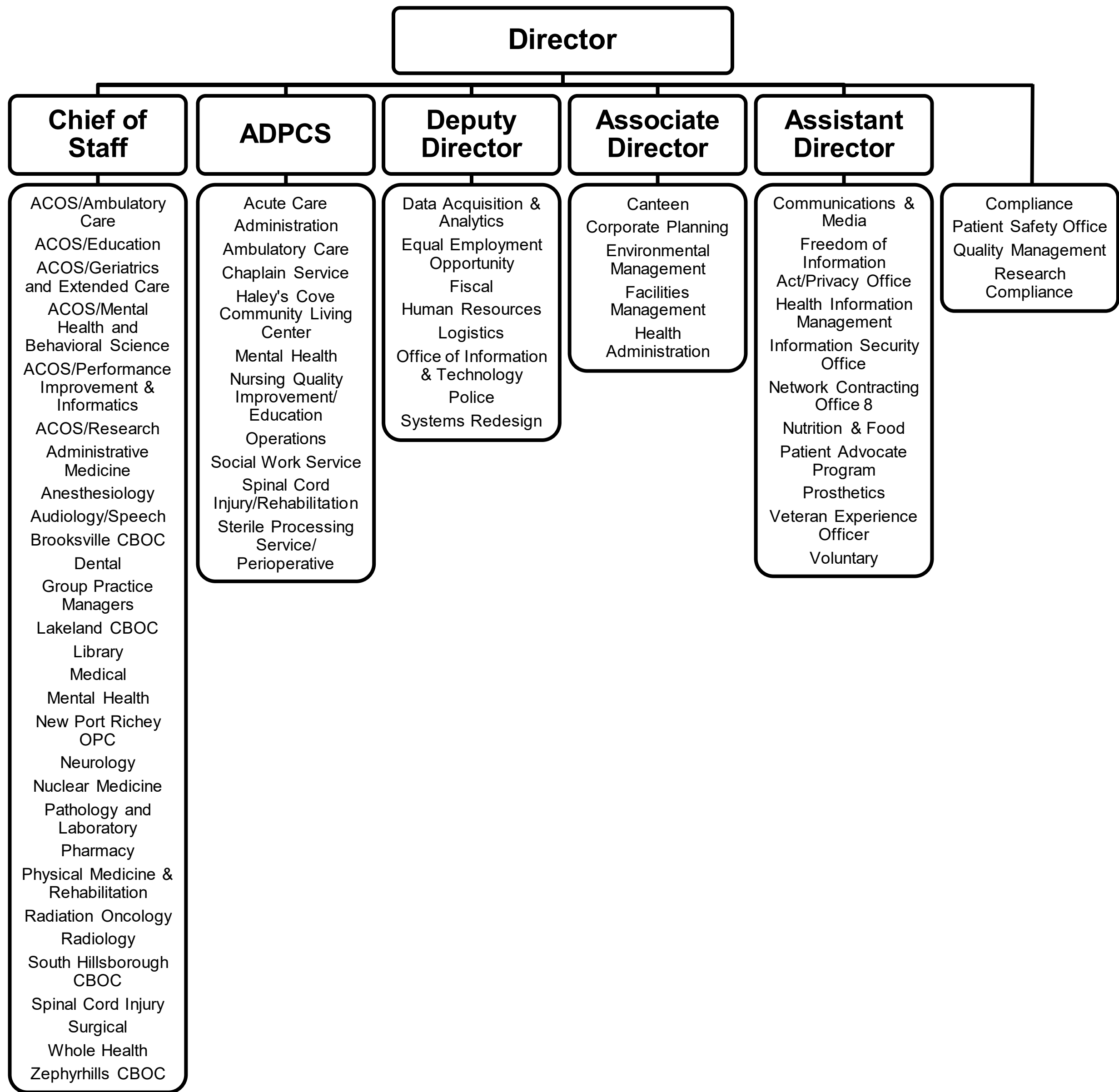

Figure 3. *Hospital organizational chart.*

Source: James A. Haley Veterans' Hospital (received March 22, 2021).

ACOS = associate chief of staff.

CBOC = community-based outpatient clinic.

OPC = outpatient clinic.

At the time of the OIG virtual review, the executive team had worked together for approximately six months. The ADPCS, assigned in April 2010, was the most tenured leader. In June 2020, the Director was detailed to VISN 7. Subsequently, the Deputy Director and Associate Director were assigned to acting roles as the Director and Deputy Director, respectively. In October 2020, the Chief, Human Resources was assigned as the acting Associate Director (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	June 7, 2020 (acting) July 26, 2015 (permanent)
Deputy Director	June 7, 2020 (acting) January 10, 2016 (permanent)
Chief of Staff	July 8, 2018
Associate Director for Patient Care Services	April 11, 2010
Associate Director	October 4, 2020 (acting) July 24, 2016 (permanent)
Assistant Director	March 24, 2013

Source: James A. Haley Veterans' Hospital Senior Strategic Business Partner (received March 22, 2021).

To help assess the hospital executive leaders' engagement, the OIG interviewed the Director, Deputy 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.

The Director, Chief of Staff, and ADPCS 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. The Deputy and Associate Directors, who had served in their roles for less than one year, could not elaborate on initiatives to improve selected SAIL and CLC SAIL measures.

In individual interviews, the Director, Chief of Staff, and ADPCS 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 Governance Board, which had the responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Governance Board oversaw various working groups such as the Resource Management, Clinical Executive, and Patient Care Executive Boards.

These 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 Governance Board (see figure 4).

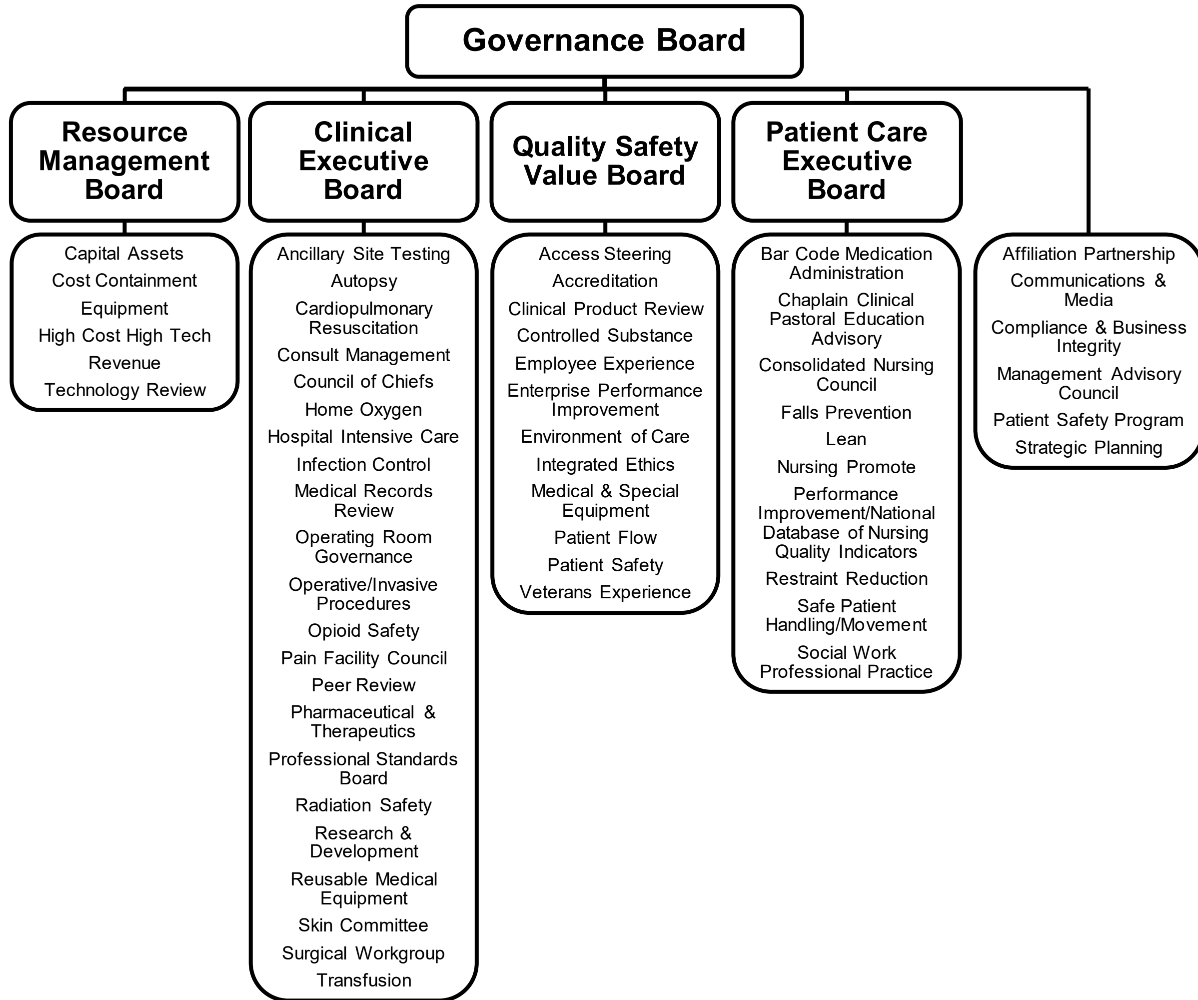

Figure 4. *Hospital committee reporting structure.*
Source: James A. Haley Veterans' Hospital (received March 22, 2021).

Budget and Operations

The hospital's FY 2020 annual medical care budget of $1,339,500,435 increased 18 percent compared to the previous year's budget of $1,132,317,793.[11] When asked about the effect of this change on the hospital's operations, the Director indicated the budget was adequate. However, the Director reported that the hospital is in the most populated and fastest growing county in

[11] VHA Support Service Center.

Florida and, as a result, the workload had increased. To address this, executive leaders reported building internal capacity and expanding primary care teams.

Staffing

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

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[15] The Director confirmed that the medical records technician and general engineer positions remained a challenge to fill. The Director discussed an effort to mitigate the shortage of medical records technicians through a formal agreement with VISN 9. Additionally, the Director stated that hospital leaders used bonuses, compensatory time, and overtime to retain general engineers. Further, leaders reported that the hospital secured intern positions through the VA Technical Career Field to alleviate staffing shortages.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Medical Technologist	1. Motor Vehicle Operator
2. Nurse Anesthetist	2. Purchasing
3. Orthotist and Prosthetist	3. Medical Records Technician
4. Diagnostic Radiologic Technologist	4. General Engineering
5. Nursing Assistant	5. Cook

Source: VA OIG.

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

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

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

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

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[16] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[17] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on hospital leaders.

To assess employee attitudes toward hospital leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[18] Table 3 provides relevant survey results for VHA, the hospital, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the hospital averages for the selected survey leadership questions were higher than the VHA averages.[19] Scores for the Director, Deputy Director, Chief of Staff, and Assistant Director were generally higher than the hospital averages. However, scores for the ADPCS and Associate Director highlighted opportunities to adopt servant leadership traits.[20]

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

Questions/ Survey Items	Scoring	VHA Average	Hospital Average	Director Average	Deputy Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	76.0	89.6	77.4	91.4	72.3	72.0	80.4

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

[17] "AES Survey History."

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

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

[20] The 2020 All Employee Survey results are not reflective of employee satisfaction with the current acting Associate Director, who assumed the role after the survey was administered. The results are also not fully reflective of the acting Director and acting Deputy Director, who began their positions during the survey period.

Questions/ Survey Items	Scoring	VHA Average	Hospital Average	Director Average	Deputy Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.5	3.7	4.5	3.7	4.7	3.6	3.4	4.0
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.8	4.4	3.9	4.6	3.7	3.6	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	3.9	4.6	4.0	4.7	4.0	3.7	4.2

Source: VA All Employee Survey (accessed February 22, 2021).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[21] The hospital averages for the selected survey questions were similar to the VHA averages. Scores related to the executive leaders were generally similar to or better than those for VHA and the hospital.

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

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

Questions/ Survey Items	Scoring	VHA Average	Hospital Average	Director Average	Deputy Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.4	4.0	4.7	4.0	3.8	4.2
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.2	3.8	4.3	4.1	3.5	3.9
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	1.3	1.6	1.0	0.1	1.5	1.4	1.1

Source: VA All Employee Survey (accessed February 22, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[22] 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.[23]

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. With exception of the Associate Director, the hospital and executive leadership team averages for the selected survey questions were similar to or better than the VHA averages. 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	Hospital Average	Director Average	Deputy Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.4	4.0	4.7	4.1	3.6	4.1
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.2	4.8	4.2	4.8	4.1	4.0	4.3
Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.4	4.0	4.7	3.8	3.6	4.1

Source: VA All Employee Survey (accessed February 22, 2021).

Patient Experience

To assess patient experiences with the hospital, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through September 30, 2020. VHA's Patient

[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] "Stand Up to Stop Harassment Now!"

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 James A. Haley Veterans' Hospital.[24] For this hospital, 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	Hospital 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	71.8
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	86.5
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	86.8

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by

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

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 hospital survey results were generally similar to or more favorable than the corresponding VHA averages; however, opportunities appeared to exist for leaders to improve access to urgently-requested outpatient appointments.

Leaders explained that while the population the hospital served was growing, the number of female veterans was increasing more quickly than the number of male veterans. Leaders discussed actions taken to make women veterans feel like part of the hospital, which included adding a women's imaging area, women's entrance, and women-staffed clinics.

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

Questions	Scoring	VHA*		Hospital	
		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	72.3	64.9
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	84.5	89.2
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	85.0	81.2

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 hospital averages are based on 683–692 male and 37–38 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*		Hospital	
		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	57.4	35.0
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).	59.5	53.0	63.3	62.9
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	79.3	70.7

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

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

The hospital averages are based on 726–2,126 male and 69–157 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*		Hospital	
		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	49.8	41.5

Questions	Scoring	VHA*		Hospital	
		Male Average	Female Average	Male Average	Female Average
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	57.1	55.3
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).	75.1	72.2	76.8	74.8

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

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

The hospital averages are based on 677–1,892 male and 55–140 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 hospital inspections most recently performed by the OIG and The Joint Commission (TJC).[27] At the time of the OIG review, the hospital had closed all recommendations for improvement issued since the previous CHIP site visit conducted in February 2019 and from a prior focused OIG report on ophthalmology equipment concerns published in November 2019.[28]

[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."

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

[28] VA OIG, *Ophthalmology Equipment and Related Concerns at the James A. Haley Veterans' Hospital, Tampa, Florida*, Report No. 19-07095-253, November 7, 2019.

The OIG team noted the hospital's current accreditation by the Commission on Accreditation of Rehabilitation Facilities.[29] The OIG also noted results from the Long Term Care Institute's inspection of the hospital's CLC, and the Paralyzed Veterans of America's inspection of the hospital's spinal cord injury/disease unit and related services.[30]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital, Tampa, Florida*, Report No. 19-00011-255, November 14, 2019)	February 2019	7	0
OIG (*Ophthalmology Equipment and Related Concerns at the James A. Haley Veterans' Hospital, Tampa, Florida,* Report No. 19-07095-253, November 7, 2019)	March 2019	4	0
TJC Hospital Accreditation TJC Behavioral Health Care Accreditation TJC Home Care Accreditation	July 2019	43 3 7	0 0 0

Source: OIG and TJC (inspection/survey results received from the Accreditation Manager on March 23, 2021).

Identified Factors Related to Possible Lapses in Care and Hospital 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 hospital, 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.

[29] 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."

[30] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement; compliance program development; and review in long term care, hospice, and other residential care settings." The Paralyzed Veterans of America inspection took place January 8–9, 2020. This veterans service organization review does not result in accreditation status.

Table 11 lists the reported patient safety events from February 9, 2019 (the prior OIG CHIP site visit), through March 22, 2021.[31]

Table 11. Summary of Selected Organizational Risk Factors (February 9, 2019, through March 22, 2021)

Factor	Number of Occurrences
Sentinel Events	16
Institutional Disclosures	6
Large-Scale Disclosures	0

Source: James A. Haley Veterans' Hospital Patient Safety and Risk Managers (received March 23, 2021).

The Director spoke knowledgeably about serious adverse event reporting. The Chief of Patient Safety notifies the Director about serious adverse events during the morning report. The Director stated that the Chief of Staff reports serious adverse events to the Director within 24 hours. The Director reported collaborating with the Chief of Staff, Quality Manager, Risk Manager, and Patient Safety Manager to determine when an institutional disclosure was warranted.

The OIG received details of 16 sentinel events and six institutional disclosures that occurred from February 9, 2019, through March 22, 2021, and identified an organizational risk factor related to patient falls. Seven of the 16 sentinel events were classified as falls resulting in major injury. Three of the falls resulted in death.

The Patient Safety Manager reported that the Falls Prevention Committee implemented strategies to keep patients safe, and the hospital collaborated with the VISN 8 Patient Safety Center of Inquiry to advance evidence-based practices involving falls management. Additionally, the manager reported completing the FY 2021 Aggregated Falls Patient Safety Assessment Tool,

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[31] 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 John A. Haley Veterans' Hospital is a highest complexity (1a) affiliated facility 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."

which provided information about interdisciplinary approaches, data analysis processes, education initiatives, and improvement actions to prevent falls.

Veterans Health Administration Performance Data for the Hospital

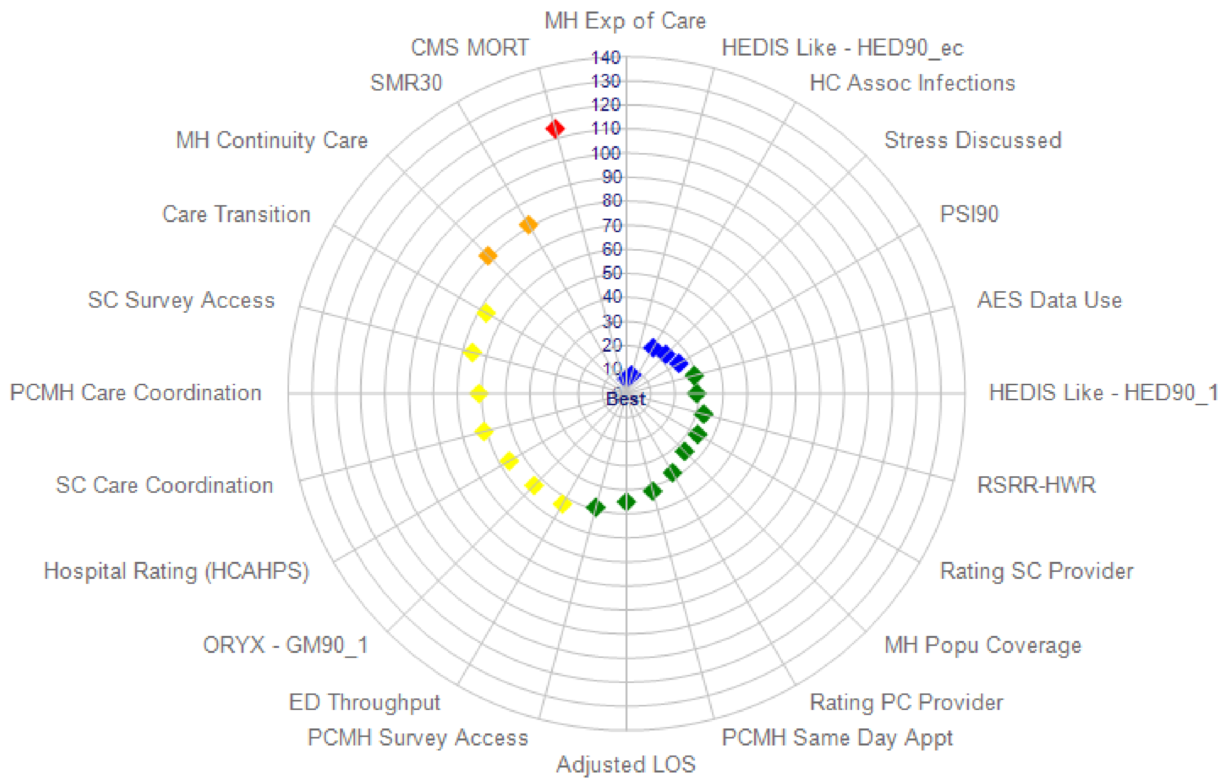
The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[32] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[33]

Figure 5 illustrates the hospital's quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2020. Figure 5 shows the hospital'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) experience (exp) of care, stress discussed, rating (of) specialty care (SC) provider, and adjusted length of stay (LOS)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, MH continuity (of) care, and Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate (MORT)).[34]

[32] "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.)

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

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



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

Figure 5. *Hospital quality of care and efficiency metric rankings for fiscal year 2020 quarter 4 (as of September 30, 2020).*

Source: VHA Support Service Center.

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

Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[35] The model "leverages much of the same data" used in CMS's *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[36]

Figures 6 illustrates the hospital's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2020. Figure 6 displays the hospital's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of catheter in bladder–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and discharged to community (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, outpatient emergency department (ED) visit (SS) and high risk PU (LS)).[37] According to the Chief of Staff, wound care nurses trained clinicians to improve documentation to address pressure ulcers. Prior to outpatient emergency department visits, a CLC nurse practitioner assesses the patient to determine if the visit is needed.

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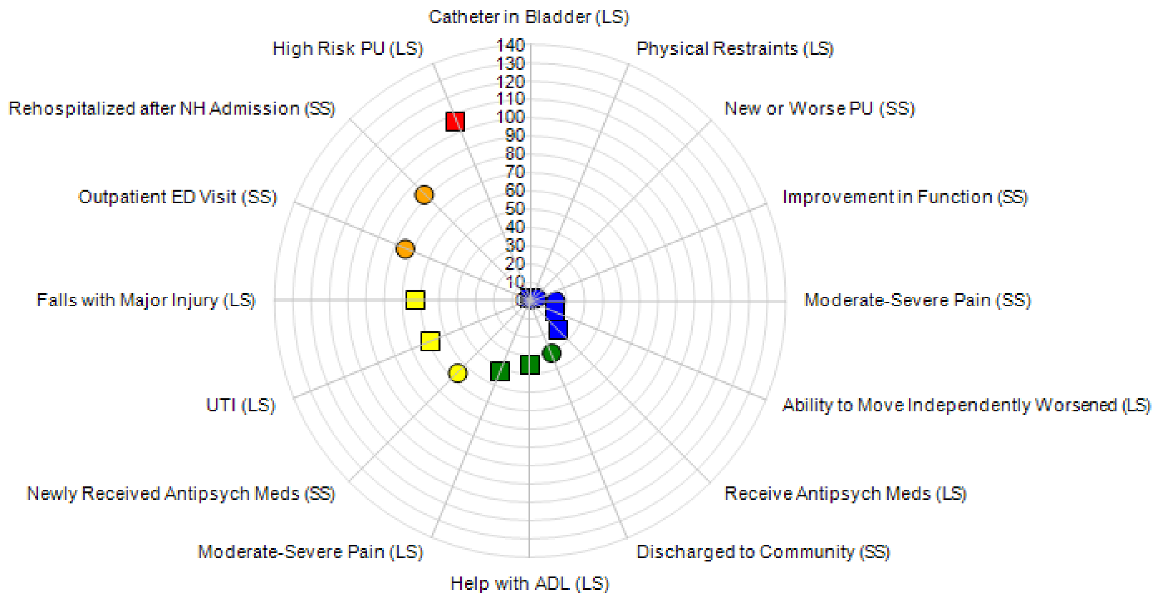
[35] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks,* July 16, 2021.

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

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



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

Figure 6. *CLC quality measure rankings for FY 2020 quarter 4 (as of September 30, 2020).*

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

When the OIG conducted this inspection, the executive leadership team had worked together for approximately six months, and three leaders were serving in acting roles. The executive leaders were able to discuss interim strategies to address nonclinical occupational shortages.

Selected employee satisfaction survey responses generally demonstrated positive results for the leaders. However, survey responses highlighted opportunities for the ADPCS and Associate Director to adopt servant leadership traits. Selected patient experience survey scores were generally similar to or more favorable than the corresponding VHA averages; however, opportunities appeared to exist for leaders to improve access to urgently needed outpatient appointments.

The OIG's review of the hospital's accreditation findings, sentinel events, and disclosures of adverse patient events identified an organizational risk factor related to patient falls.

The Director, Chief of Staff, and ADPCS were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures. The Deputy and Associate Directors, who had served in their roles for less than one year, could not elaborate on initiatives to improve selected SAIL and CLC SAIL

measures. In individual interviews, the Director, Chief of Staff, and ADPCS 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.

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.[38] 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.[39]

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."[40] "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."[41]

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 hospital and its leaders' subsequent responses. The OIG analyzed performance in the following domains:

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

The OIG also surveyed hospital 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 hospital and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

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[38] "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.

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

[40] 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."

[41] 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.[42] 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.[43] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[44]

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 hospital'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 hospital's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[45] 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."[46] 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

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

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

[44] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

[45] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

[46] VHA Directive 1026.01.

Next, the OIG assessed the hospital's processes for conducting protected peer reviews of clinical care.[47] 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."[48] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[49] 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[50]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[51]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the hospital'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."[52] 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; (2) Policy

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[47] 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."

[48] VHA Directive 1190.

[49] VHA Directive 1190.

[50] VHA Directive 1190.

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

[52] "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.)

development; (3) Data stewardship; and 4) Fiduciary responsibility for select specialty programs."[53] The hospital'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[54]

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.[55]

Quality, Safety, and Value Findings and Recommendation

The hospital 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 a significant weakness with the Surgical Workgroup's processes.

VHA requires medical facilities with surgery programs to have a surgical work group responsible for the "monthly review of surgical deaths."[56] The OIG reviewed Surgical Workgroup meeting minutes from February 26, 2020, through February 24, 2021, and found that the group did not review surgical deaths in 7 of 13 monthly meetings. The failure to review surgical deaths could result in missed opportunities for oversight. The Chief of Surgery reported being unaware of the requirement to conduct a monthly review of surgical deaths.

Recommendation 1

1. The Director evaluates and determines additional reasons for noncompliance and ensures the Surgical Workgroup conducts a monthly review of surgical deaths.

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[53] "NSO Reporting, Resources, & Tools."

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

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

[56] VHA Directive 1102.01(1).

Hospital concurred.

Target date for completion: January 2022

Hospital Response: The Chief of Surgical Services was not aware of the requirements to report mortality reviews of surgical deaths at the monthly Surgical Workgroup. Therefore, The Chief of Surgical Services will continue to conduct mortality reviews of all surgical deaths and report at the monthly Surgical Workgroup.

Reporting Committee: The compliance of Surgical Deaths will be monitored by reviewing the Surgical Workgroup minutes and compliance reported to the Clinical Executive Board Committee monthly. Note: If no surgical mortality occurred, it will be annotated in the Surgical Workgroup Minutes as "no surgical deaths for the month".

Benchmark: 90%

Frequency of Monitoring: To monitor until 90% compliance is maintained for six consecutive 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."[57] 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."[58]

VA requires all RNs to hold at least one active, unencumbered license.[59] 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.[60] 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.[61] 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.[62]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 137 RNs hired from January 1, 2020, through February 22, 2021. The OIG determined whether

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

The OIG also reviewed credentialing files for 31 of the 137 RNs to determine whether hospital staff completed primary source verification prior to the appointment.

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

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

[59] VA 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."

[60] 38 U.S.C. § 7402.

[61] VHA Directive 2012-030.

[62] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[63] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[64]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[65] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[66]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[67] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[68]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of 50 patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments
- Medication orders used proper name

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

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

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

[66] Centers for Disease Control and Prevention, *Vaccine Storage and Handling Kit*, May 2014. "The cold chain begins with the cold storage unit at the manufacturing plant, extends through transport of vaccine(s) to the distributor, then delivery and storage at the provider facility, and ends with administration of vaccine to the patient. Appropriate storage conditions must be maintained at every link in the cold chain." Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*.

[67] Food and Drug Administration, "FDA News Release: COVID-19 Update: FDA Broadens Emergency Use Authorization for Veklury (remdesivir) to Include All Hospitalized Patients for Treatment of COVID-19," August 28, 2020.

[68] Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19," October 22, 2020.

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
    - Potential pregnancy
    - Kidney assessment (estimated glomerular filtration rate)[69]
    - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[70]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

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

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*; inform patients and/or caregivers that remdesivir was not an FDA-approved medication; provide the option to refuse the medication; and advise patients and/or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[71] Of the 50 patients who received remdesivir, the OIG determined that healthcare providers did not

- provide 50 percent of patients or caregivers with the *Fact Sheet for Patients and Parents/Caregivers*,
- inform 66 percent of patients or caregivers that remdesivir was not an FDA-approved medication,
- provide 80 percent of patients or caregivers the option to refuse the medication,

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[69] "Estimated Glomerular Filtration Rate (eGFR)," National Kidney Foundation, accessed December 9, 2020, https://www.kidney.org/atoz/content/gfr. "Estimated glomerular filtration rate [eGFR] is the best test to measure your level of kidney function and determine your stage of kidney disease."

[70] "Alanine transferase," National Cancer Institute, accessed December 9, 2020, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/alanine-transferase. Alanine transferase, also referred to as serum glutamate pyruvate transaminase, is "an enzyme found in the liver and other tissues," of which a high level may be indicative of liver damage.

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

- inform 38 percent of patients or caregivers of the risks and benefits of remdesivir, and
- advise 54 percent of patients or caregivers of the alternatives to receiving remdesivir prior to administration.

This could have resulted in the patient or caregiver lacking information needed to make a fully informed decision to receive the medication. The Chief of Hospitalists stated that documentation of every element discussed with the patient or caregiver would be redundant because all elements are addressed in the fact sheet, which was provided during the discussion. However, the OIG did not find evidence that every patient received the fact sheet.

Given the FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.[72]

[72] Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19," October 22, 2020.

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.[73] 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.[74] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[75]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[76] 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.[77] The hospital 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

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

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

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

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

[77] 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.

- relevant documents;
- the electronic health records of 50 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 hospital 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.[78]

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."[79] 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.[80]

The hospital 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 hospital 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 46 patients who were transferred from the hospital 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 found a deficiency with transfer documentation.

VHA requires that the Chief of Staff and ADPCS ensure transferring physicians or assigned designees "send all pertinent medical records available, including…documentation of the

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

[79] VHA Directive 1094.

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

patient's advance directive made prior to transfer, if any" to the receiving facility.[81] The OIG determined that four of six applicable inter-facility transfers lacked evidence that staff sent the advance directive to the receiving facility. As a result, there was no assurance that receiving facility staff could determine patient preferences regarding future healthcare decisions in the event the patient no longer had decision-making capability.[82] The Director of the Emergency Department stated that transferring providers were not aware of the requirement. Due to the small number of patients identified for this review element, the OIG made no recommendation.

[81] VHA Directive 1094.

[82] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.

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."[83] 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."[84] 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[85]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[86]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[87]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[88]

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

[84] VHA Directive 2012-026.

[85] 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."

[86] 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."

[87] 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."

[88] 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.[89] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[90] 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 OIG found the hospital met some of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with Disruptive Behavior Committee member participation and staff training.

VHA requires the Chief of Staff and ADPCS to be responsible for establishing a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; the patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the Union Safety Committee.[91] The committee chairperson reported that the Disruptive Behavior Committee operated virtually and reviewed behavioral event reports via email. The OIG reviewed emails from February through March 2021 and found that the patient advocate was not included on 3 of 12 emails, a Prevention and Management of Disruptive Behavior Program representative was not included on 2 of 12 emails, and a VA police representative was not included on 8 of 12 emails. This could have resulted in a lack of knowledge and expertise when assessing patients' disruptive behavior.[92] Additionally, the OIG found that the committee lacked administrative support. The chairperson reported competing work priorities and an administrative support staff position vacancy as the reasons for noncompliance.

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

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

[91] VHA Directive 2010-053.

[92] VHA Directive 2012-026.

Recommendation 2

2. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure all required members participate in disruptive behavior event reviews.

Hospital concurred.

Target date for completion: January 2022

Hospital response: The Chairperson of the Disruptive Behavior Committee will coordinate meetings to ensure all required members attend meetings.

Reporting Committee: Compliance for monitoring attendance of required members of the Disruptive Behavior Committee will be reported to monthly to Quality Safety Value Board.

Benchmark: 90%

Frequency of Monitoring: To monitor until 90% compliance is maintained for six consecutive months.

VHA requires that staff are assigned prevention and management of disruptive behavior part 1 training when hired and additional levels of training based on the risk level assigned to their work area.[93] The OIG found that 4 of 30 selected staff did not complete the required part 1 training. This could result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Coordinator explained that the noncompliance was due to a lack of supervisory oversight.

Recommendation 3

3. The Director evaluates and determines any additional reasons for noncompliance and ensures that staff complete the required prevention and management of disruptive behavior training.

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

Hospital concurred.

Target date for completion: October 2021

Hospital response: All Service Chiefs and Supervisors will ensure all new employees will complete Part 1 of Prevention and Management of Disruptive Behavior (PMDB) within 90 days of hire.

Reporting Committee: The compliance for monitoring completion of PMDB Part 1 Training within 90 days of hire for all new employees will be monitored by the PMDB Coordinator/Master Instructor and will be reported monthly to Quality Safety Value Board.

Benchmark: 90%

Frequency of Monitoring: To monitor until 90% compliance is maintained for six consecutive months.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their hospital, the OIG conducted a detailed review of eight clinical and administrative areas and provided three 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 hospital, 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 three OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and ADPCS. The intent is for these leaders to use the 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 hospital response • VHA performance data (hospital) • VHA performance data (CLC)	• None	• None
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback	The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this hospital 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 Workgroup conducts a monthly review of surgical deaths.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• None	• None
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	• All required members participate in disruptive behavior event reviews. • Staff complete the required prevention and management of disruptive behavior training.

Appendix B: Hospital Profile

The table below provides general background information for this highest complexity (1a) affiliated hospital reporting to VISN 8.[1]

Table B.1. Profile for James A. Haley Veterans' Hospital (673)
(October 1, 2017, through September 30, 2020)

Profile Element	Hospital Data FY 2018*	Hospital Data FY 2019	Hospital FY 2020‡
Total medical care budget	$1,032,304,203	$1,132,317,793	$1,339,500,435
Number of: • Unique patients	97,045	100,457	111,067
• Outpatient visits	1,424,039	1,437,900	1,437,387
• Unique employees§	4,573	4,852	5,246
Type and number of operating beds: • Community living center	64	64	64
• Domiciliary	33	33	33
• Medicine	134	134	134
• Mental health	40	40	40
• Neurology	2	2	2
• Rehabilitation medicine	66	66	66
• Spinal cord	100	100	100
• Surgery	60	60	60
Average daily census: • Community living center	49	40	34
• Domiciliary	24	23	17
• Medicine	104	106	95
• Mental health	34	27	20
• Neurology	3	3	2
• Rehabilitation medicine	50	50	32

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

Profile Element	Hospital Data FY 2018*	Hospital Data FY 2019	Hospital FY 2020[‡]
• Spinal cord	81	89	73
• Surgery	25	25	15

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 hospital 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
New Port Richey, FL	673BZ	24,276	9,045	Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Nephrology Plastic Podiatry Pulmonary/ Respiratory disease	EKG Laboratory & Pathology Radiology	Nutrition Pharmacy Prosthetics Weight management
Lakeland, FL	673GB	18,776	392	Endocrinology Podiatry Rheumatology	EKG	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
Brooksville, FL	673GC	9,713	7,011	Dermatology Endocrinology Gastroenterology Infectious disease Nephrology Plastic Podiatry Vascular	EKG	Nutrition Pharmacy Prosthetics Social work Weight management
Zephyrhills, FL	673GF	5,451	–	Dermatology Endocrinology	EKG	Pharmacy Weight management
Riverview, FL	673GG	10,286	10,889	Dermatology Infectious disease Pulmonary/ Respiratory disease Plastic Podiatry	Radiology	Nutrition Pharmacy Prosthetics Social work Weight management
Lecanto, FL	673GH	10,466	8,345	Dermatology Hematology/ Oncology Infectious disease Plastic	–	Nutrition Pharmacy Social work Weight management
Tampa, FL	673QA	–	1,315	Eye Poly-Trauma	–	Pharmacy Dental
Tampa, FL	673QB	–	50,783	Eye	–	Social work

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Lakeland, FL	673QC	–	11,266	Dermatology Infectious disease Nephrology Plastic Podiatry Vascular	Radiology	Nutrition Pharmacy Prosthetics Weight management
New Port Richey, FL	673QG	–	6,885	–	–	–
Zephyrhills, FL	673QI	162	3,526	–	–	Nutrition
Tampa, FL	673QJ	33,262	12,174	Dermatology General surgery GYN Podiatry	EKG	Dental Nutrition Pharmacy Prosthetics Social work Weight management

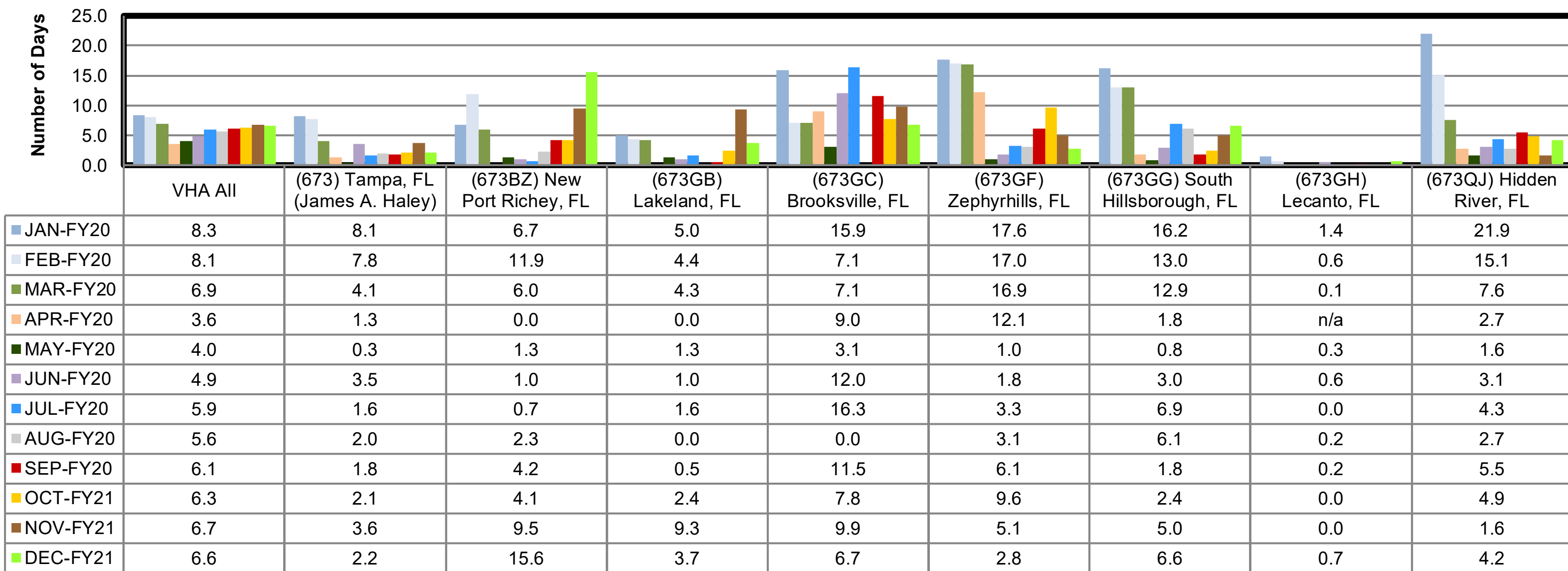
Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

The OIG omitted (673BV) Tampa, FL – VADOM; (673QD) New Port Richey, FL; (673QD) Deer Park, FL; (673QE) Highway Nineteen, FL; (673QF) Winners Circle, FL; and (673QH) Bruce B. Downs Boulevard, FL, as no data were reported.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days



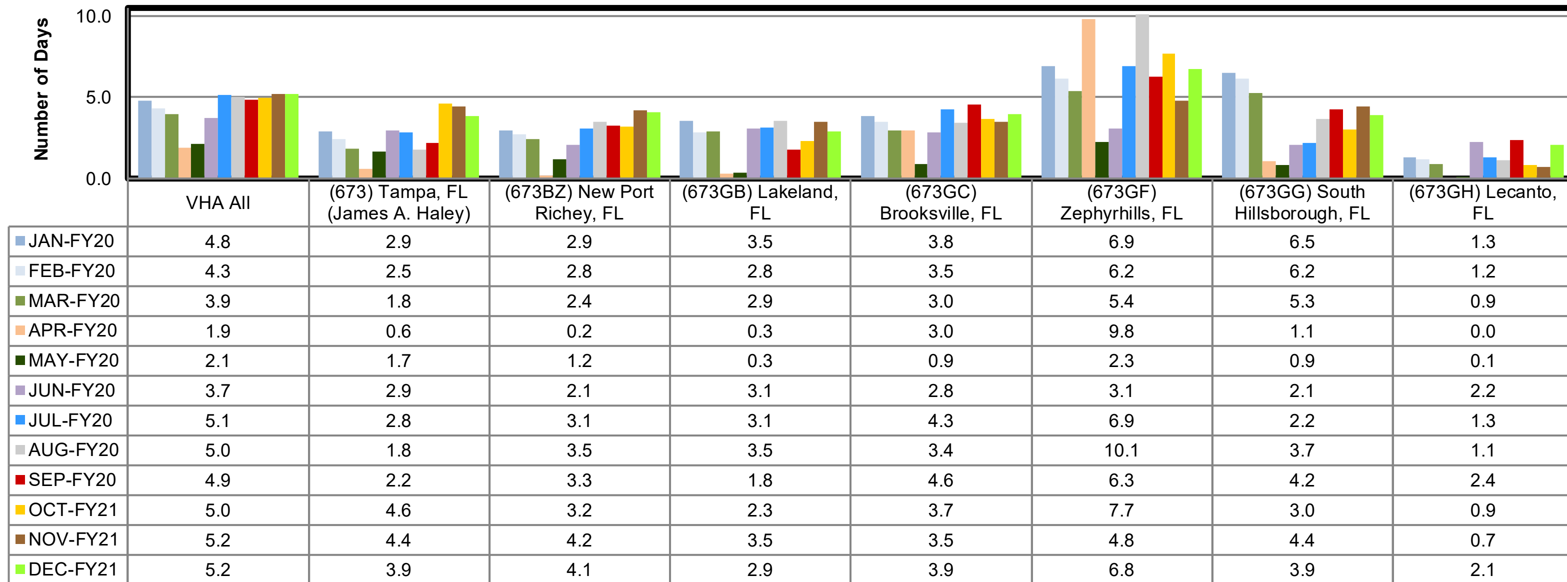
	VHA All	(673) Tampa, FL (James A. Haley)	(673BZ) New Port Richey, FL	(673GB) Lakeland, FL	(673GC) Brooksville, FL	(673GF) Zephyrhills, FL	(673GG) South Hillsborough, FL	(673GH) Lecanto, FL	(673QJ) Hidden River, FL
JAN-FY20	8.3	8.1	6.7	5.0	15.9	17.6	16.2	1.4	21.9
FEB-FY20	8.1	7.8	11.9	4.4	7.1	17.0	13.0	0.6	15.1
MAR-FY20	6.9	4.1	6.0	4.3	7.1	16.9	12.9	0.1	7.6
APR-FY20	3.6	1.3	0.0	0.0	9.0	12.1	1.8	n/a	2.7
MAY-FY20	4.0	0.3	1.3	1.3	3.1	1.0	0.8	0.3	1.6
JUN-FY20	4.9	3.5	1.0	1.0	12.0	1.8	3.0	0.6	3.1
JUL-FY20	5.9	1.6	0.7	1.6	16.3	3.3	6.9	0.0	4.3
AUG-FY20	5.6	2.0	2.3	0.0	0.0	3.1	6.1	0.2	2.7
SEP-FY20	6.1	1.8	4.2	0.5	11.5	6.1	1.8	0.2	5.5
OCT-FY21	6.3	2.1	4.1	2.4	7.8	9.6	2.4	0.0	4.9
NOV-FY21	6.7	3.6	9.5	9.3	9.9	5.1	5.0	0.0	1.6
DEC-FY21	6.6	2.2	15.6	3.7	6.7	2.8	6.6	0.7	4.2

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 omitted (673BV) Tampa, FL – VADOM; (673QA) Forty Sixth Street North, FL; (673QB) Forty Sixth Street South, FL; (673QC) West Lakeland, FL; (673QD) Deer Park, FL; (673QE) Highway Nineteen, FL; (673QF) Winners Circle, FL; (673QG) Little Road, FL; (673QH) Bruce B. Downs Boulevard, FL; and (673QI) Medical View Lane, FL, as no data were reported.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA All	(673) Tampa, FL (James A. Haley)	(673BZ) New Port Richey, FL	(673GB) Lakeland, FL	(673GC) Brooksville, FL	(673GF) Zephyrhills, FL	(673GG) South Hillsborough, FL	(673GH) Lecanto, FL
JAN-FY20	4.8	2.9	2.9	3.5	3.8	6.9	6.5	1.3
FEB-FY20	4.3	2.5	2.8	2.8	3.5	6.2	6.2	1.2
MAR-FY20	3.9	1.8	2.4	2.9	3.0	5.4	5.3	0.9
APR-FY20	1.9	0.6	0.2	0.3	3.0	9.8	1.1	0.0
MAY-FY20	2.1	1.7	1.2	0.3	0.9	2.3	0.9	0.1
JUN-FY20	3.7	2.9	2.1	3.1	2.8	3.1	2.1	2.2
JUL-FY20	5.1	2.8	3.1	3.1	4.3	6.9	2.2	1.3
AUG-FY20	5.0	1.8	3.5	3.5	3.4	10.1	3.7	1.1
SEP-FY20	4.9	2.2	3.3	1.8	4.6	6.3	4.2	2.4
OCT-FY21	5.0	4.6	3.2	2.3	3.7	7.7	3.0	0.9
NOV-FY21	5.2	4.4	4.2	3.5	3.5	4.8	4.4	0.7
DEC-FY21	5.2	3.9	4.1	2.9	3.9	6.8	3.9	2.1

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 omitted (673BV) Tampa, FL – VADOM; (673QA) Forty Sixth Street North, FL; (673QB) Forty Sixth Street South, FL; (673QC) West Lakeland, FL; (673QD) Deer Park, FL; (673QE) Highway Nineteen, FL; (673QF) Winners Circle, FL; (673QG), Little Road, FL; (673QH) Bruce B. Downs Boulevard, FL; (673QI) Medical View Lane, FL; and (673QJ) Hidden River, FL, as no data were reported.

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

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use	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
Hospital Rating (HCAHPS)	Overall rating of hospital stay (inpatient only)	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

Measure	Definition	Desired Direction
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PC provider	Rating of 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: Community Living Center (CLC) Strategic Analytics for Improvement and Learning (SAIL) Measure Definitions

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 13, 2021

From: Director, VISN 8: VA Sunshine Healthcare Network (10N8)

Subj: Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, Florida

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

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

I have reviewed the VAOIG's report as well as the James A. Haley Veterans' Hospital response and concur with the findings, recommendations, and action plans submitted by the VA Medical Center, Tampa, Florida.

(Original signed by:)

Miguel H. LaPuz, MD, MBA
Network Director, VISN 8

Appendix H: Hospital Director Comments

Department of Veterans Affairs Memorandum

Date: September 2, 2021

From: Director, James A. Haley Veterans' Hospital (673/00)

Subj: Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, Florida

To: Director, VA Sunshine Healthcare Network (10N8)

1. I have reviewed and concur with the attached response to the VA OIG's request for an initial response regarding the CHIP review conducted at the James A. Haley VA Medical Center on March 22, 2021.

2. We appreciate the OIG's and VISN's partnership in ensuring exceptional service to the Veterans we are proud to serve.

(Original signed by:)

Melissa A. Sundin
Interim Director

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