



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare  
Inspection of the Orlando  
VA Healthcare System  
in Florida



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**Figure 1.** Orlando VA Healthcare System in Florida.

Source: <https://vaww.va.gov/directory/guide/> (accessed March 18, 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 Orlando VA Healthcare System and 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<sup>1</sup>
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 Orlando VA Healthcare System 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 healthcare system'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 healthcare system and other Veterans Health Administration (VHA)

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

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

## Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued four 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 healthcare system's leadership team consisted of the Director, Chief of Staff, acting Associate Director for Patient Care Services, acting Associate Director, and Assistant Director. Organizational communications and accountability were managed through a committee reporting structure, with Executive Leadership Committee oversight of several working groups. Leaders monitored patient safety and care through the Quality, Safety, Value Committee, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the healthcare system's leaders had worked together for approximately two months, although all but one leader had served in their positions for over one year. The Chief of Staff, who was permanently assigned in November 2015, was the most tenured leader. The acting Associate Director, assigned in January 2021, was the newest member of the leadership team.

The OIG reviewed survey results and found that employees generally appeared satisfied, and leaders appeared to maintain an environment where staff felt respected and discrimination was not tolerated. Scores for male respondents were higher than VHA averages for inpatient care experience but similar to or lower than VHA averages for outpatient care. Respondents' scores for obtaining outpatient appointments right away were generally lower than VHA averages.

The inspection team also reviewed accreditation agency findings and did not identify any substantial organizational risk factors.<sup>2</sup> However, the OIG noted concerns with staff identifying sentinel events and conducting institutional disclosures for those events.

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."<sup>3</sup>

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<sup>2</sup> 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."

<sup>3</sup> "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.)

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.<sup>4</sup>

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL and Community Living Center SAIL measures.<sup>5</sup> In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

## **COVID-19 Pandemic Readiness and Response**

The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system 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 healthcare system complied with requirements for a committee responsible for quality, safety, and value oversight functions. However, the OIG identified a weakness in the surgical work group process.

## **Registered Nurse Credentialing**

The OIG found that registered nurses hired from January 1, 2020, through February 15, 2021, were free from potentially disqualifying licensure actions. However, primary source verification of each registered nurse's license was not consistently completed prior to the appointment.

## **Medication Management**

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

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<sup>4</sup> "Strategic Analytics for Improvement and Learning (SAIL) Value Model."

<sup>5</sup> 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.

## Care Coordination

Generally, the healthcare system met expectations for an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, and nurse-to-nurse communication between facilities. However, the OIG noted a deficiency with staff sending advance directives to receiving facilities.

## High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior, including the development of a disruptive behavior policy, implementation of an employee threat assessment team, establishment of the Disruptive Behavior Committee, and completion of the annual Workplace Behavioral Risk Assessment. However, the OIG identified deficiencies with Disruptive Behavior Committee meeting attendance and staff training.

## Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued four recommendations for improvement to the System 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 system. The intent is for system 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 System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 58–59, 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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## Contents

Abbreviations .....	ii
Report Overview .....	iii
Inspection Results .....	iv
Purpose and Scope .....	1
Methodology .....	3
Results and Recommendations .....	4
Leadership and Organizational Risks.....	4
COVID-19 Pandemic Readiness and Response.....	25
Quality, Safety, and Value .....	26
Recommendation 1 .....	28
Registered Nurse Credentialing .....	30
Recommendation 2 .....	31
Medication Management: Remdesivir Use in VHA .....	32
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation .....	35
Care Coordination: Inter-facility Transfers.....	37
High-Risk Processes: Management of Disruptive and Violent Behavior .....	39
Recommendation 3 .....	41
Recommendation 4 .....	41

Report Conclusion.....	43
Appendix A: Comprehensive Healthcare Inspection Program Recommendations .....	44
Appendix B: Healthcare System Profile .....	47
Appendix C: VA Outpatient Clinic Profiles .....	49
Appendix D: Patient Aligned Care Team Compass Metrics .....	52
Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions .....	54
Appendix F: Community Living Center (CLC) Strategic Analytics for Improvement and Learning (SAIL) Measure Definitions.....	56
Appendix G: VISN Director Comments.....	58
Appendix H: Healthcare System Director Comments .....	59
OIG Contact and Staff Acknowledgments .....	60
Report Distribution .....	61



## 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 Orlando VA Healthcare System 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 healthcare system leaders so that informed decisions can be made to improve care.<sup>1</sup>

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.<sup>2</sup> Effective leadership has been cited as “among the most critical components that lead an organization to effective and successful outcomes.”<sup>3</sup> 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):<sup>4</sup>

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

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

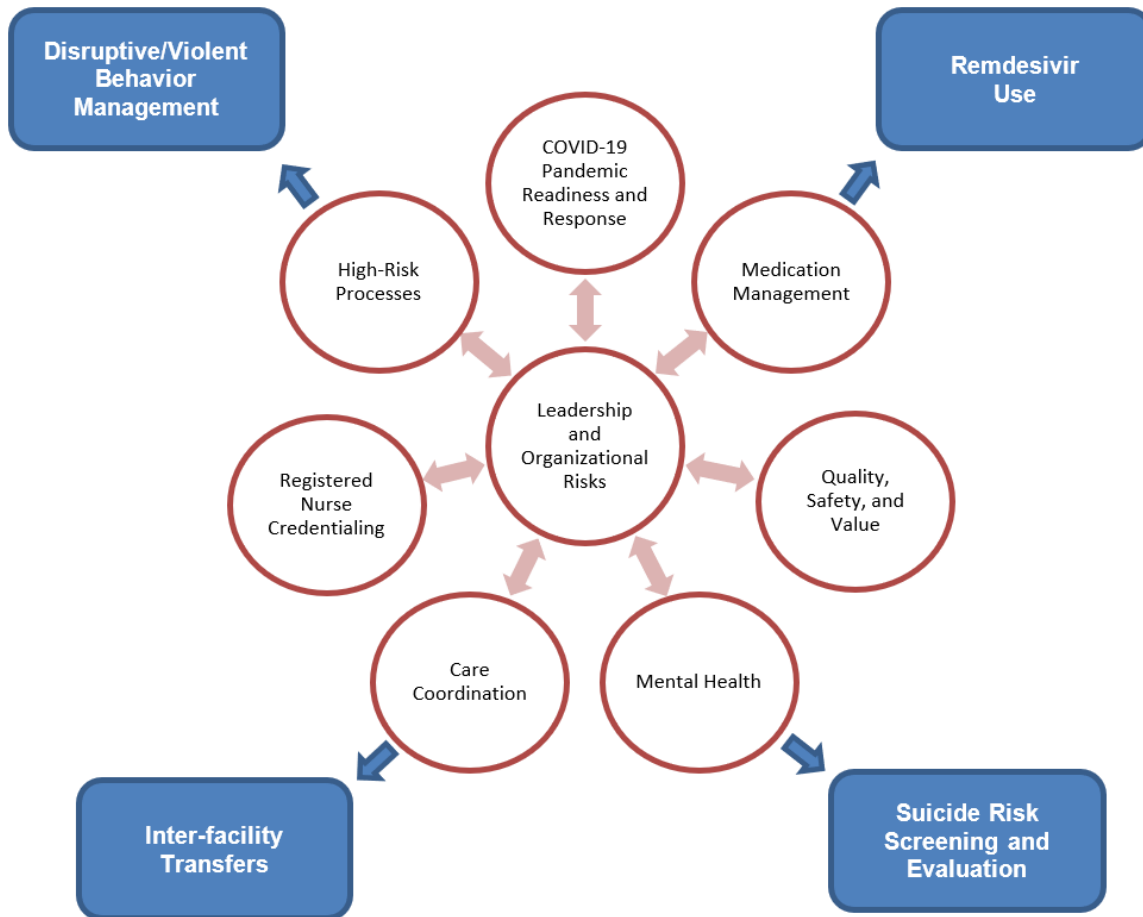
<sup>2</sup> Anam Parand et al., “The role of hospital managers in quality and patient safety: a systematic review,” *British Medical Journal*, 4, no. 9, (September 5, 2014): <https://doi.org/10.1136/bmjopen-2014-005055>.

<sup>3</sup> 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>.

<sup>4</sup> 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.

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

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



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

Source: VA OIG.

## Methodology

The Orlando VA Healthcare System includes the Orlando VA Medical Center at Lake Nona and multiple outpatient clinics in Florida. Additional details about the types of care provided by the healthcare system 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.<sup>6</sup> The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from December 3, 2016, through March 26, 2021, the last day of the unannounced multiday evaluation.<sup>7</sup> 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 healthcare system 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.<sup>8</sup> 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 healthcare system completes corrective actions. The System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system 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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<sup>6</sup> The OIG did not review VHA's internal survey results and instead focused on OIG inspections and external surveys that affect facility accreditation status.

<sup>7</sup> The range represents the time period from the prior Clinical Assessment Program site visit to the completion of the unannounced, multiday virtual CHIP visit in March 2021.

<sup>8</sup> 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.<sup>9</sup> To assess this healthcare system'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 healthcare system response
8. VHA performance data (healthcare system)
9. VHA performance data (community living center (CLC))<sup>10</sup>

### Executive Leadership Position Stability and Engagement

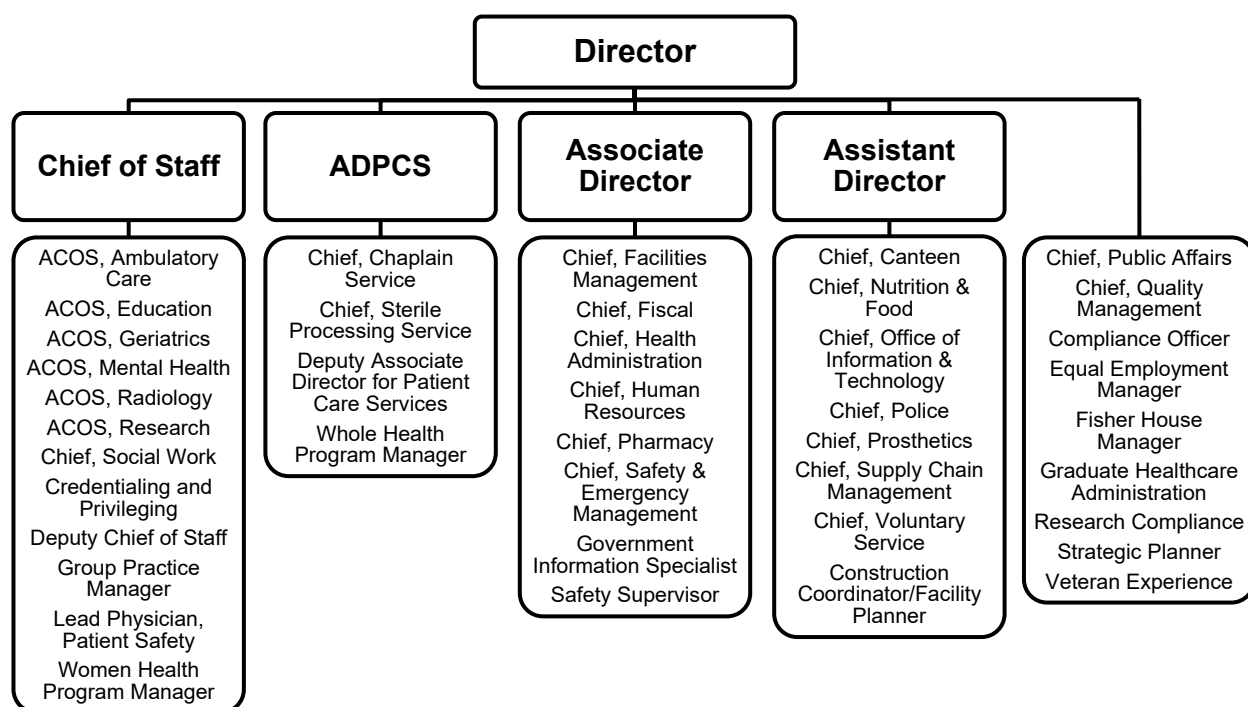
Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities.

Figure 3 illustrates this healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the Director, Chief of Staff, acting Associate Director for Patient Care Services (ADPCS), acting Associate Director, and Assistant Director. The Chief of Staff and acting ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

<sup>10</sup> 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.** Healthcare system organizational chart.

Source: Orlando VA Healthcare System (received March 22, 2021).

ACOS = associate chief of staff.

At the time of the OIG inspection, the executive team had worked together for two months, although all but one of the team members had been in their positions for more than a year (see table 1).

**Table 1. Executive Leader Assignments**

Leadership Position	Assignment Date
System Director	January 19, 2020
Chief of Staff	November 29, 2015
Associate Director for Patient Care Services	January 3, 2020 (acting)
Associate Director	January 3, 2021 (acting)
Assistant Director	September 1, 2019

Source: Orlando VA Healthcare System Chief Human Resources Specialist (received March 22, 2021).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, acting ADPCS, and acting Associate Director regarding their knowledge

of various performance metrics and their involvement and support of actions to improve or sustain performance.

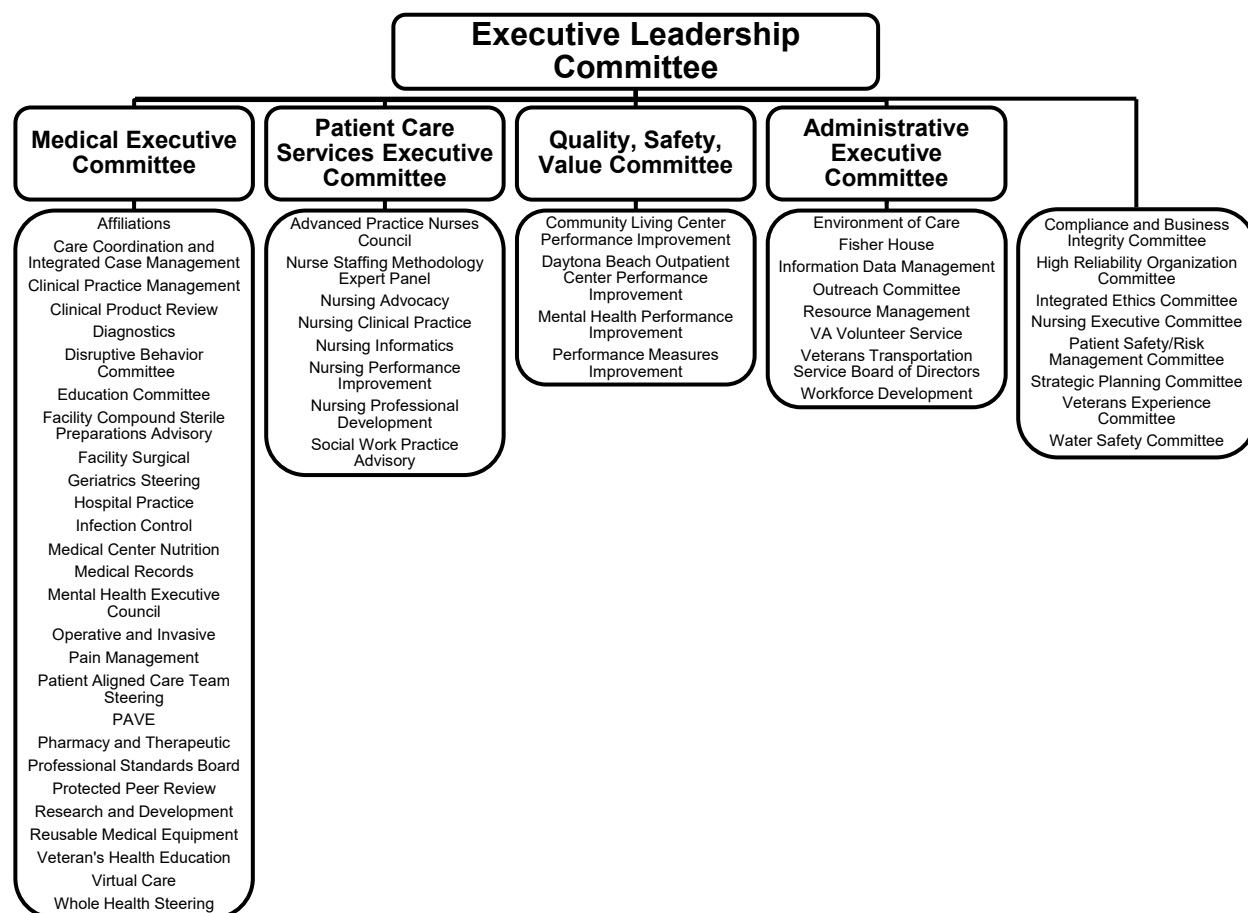
The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) and CLC SAIL measures. In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The Director served as the chairperson of the Executive Leadership Committee, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Committee oversaw various working groups such as the Medical, Patient Care Services, and Administrative Executive Committees. Leaders monitored patient safety and care through the Quality, Safety, Value Committee, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Leadership Committee (see figure 4).<sup>11</sup>

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<sup>11</sup> At the time of the virtual review, the OIG requested the healthcare system's committee reporting structure and subsequent clarification regarding committee names. The Chief of Quality Management described the healthcare system's committee reporting structure as a "living tool" that had not been updated due to the pandemic; therefore, the information provided in figure 4 may not be an accurate representation of committees reporting to the Executive Leadership Committee.





**Figure 4.** Healthcare system committee reporting structure.

Source: Orlando VA Healthcare System (received April 21, 2021).

PAVE = Preservation Amputation for Veterans Everywhere.

## Budget and Operations

The healthcare system's FY 2020 annual medical care budget of \$1,140,292,102 increased 25 percent compared to the previous year's budget of \$912,022,613.<sup>12</sup> When asked about the effect of this change on the healthcare system's operations, the Director reported that the VISN was in support of the facility investing in new positions and increasing capacity and access.

## 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.<sup>13</sup> Under the authority

<sup>12</sup> VHA Support Service Center.

<sup>13</sup> Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

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.<sup>14</sup> In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.<sup>15</sup>

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*.<sup>16</sup> The executive leaders confirmed that the registered nurses, psychiatrists, primary care physicians, medical support assistants, and custodial workers listed in table 2 remained in the top clinical and nonclinical shortages. In interviews, leaders added nursing assistants, pharmacists, pharmacy technicians, and police to the list. The acting ADPCS reported that the shortages involved staff turnover in specialty clinics, intensive care units, environmental management service, and the emergency department.

In order to alleviate some of the stress caused by the clinical shortages, system leaders reported establishing a float pool for providers and nurses. In addition, the system leaders reported increasing virtual visits to maximize providers' ability to see patients. The Chief of Staff implemented strategies to increase patient access, including hiring advanced practice registered nurses and physician assistants with recruitment and relocation incentives. System leaders also reported using the Education Debt Reduction Program to recruit and retain staff in primary care and psychiatry. Furthermore, leaders stated that the Orlando healthcare market was fast-growing and employees with specialized experience were in high demand.

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<sup>14</sup> 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.

<sup>15</sup> VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018.

<sup>16</sup> VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. RN, Manager/Head Nurse	1. Medical Support Assistance
2. Practical Nurse	2. Human Resource Management
3. Psychiatry	3. Administrative Officer
4. Primary Care	4. Custodial Worker
5. Urology	5. –

Source: VA OIG.

## Employee Satisfaction

The All Employee Survey is an “annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.”<sup>17</sup> Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health.<sup>18</sup> 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 healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey from October 1, 2019, through September 30, 2020.<sup>19</sup> Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA’s All Employee Survey. The OIG found that leaders’ averages for the selected survey questions were similar to or higher than those for VHA and the healthcare system.<sup>20</sup>

<sup>17</sup> “AES Survey History,” VA Workforce Surveys Portal, VHA Support Service Center, accessed May 3, 2021, <http://aes.vssc.med.va.gov/SurveyInstruments/Pages/default.aspx>. (This is an internal website not publicly accessible.)

<sup>18</sup> “AES Survey History.”

<sup>19</sup> Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director.

<sup>20</sup> 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. The 2020 All Employee Survey results are not reflective of employee satisfaction with the acting Associate Director, who assumed the role after the survey was administered.

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

Questions/ Survey Items	Scoring	VHA Average	Health- care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>Servant Leader Index Composite*</i>	0–100 where higher scores are more favorable	73.8	75.4	87.2	94.7	75.5	81.9	83.5
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.5	3.6	4.3	4.8	4.5	4.1	4.1
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.7	4.7	4.8	4.6	4.4	4.2
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.7	3.8	4.4	4.7	4.4	4.4	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.<sup>21</sup> The healthcare system averages for the selected survey questions were

<sup>21</sup> Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director.

similar to the VHA averages. Scores for the Director were consistently better than those for VHA and the healthcare system. Scores for the other leaders were similar to or better than those for VHA and the healthcare system.

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

Questions/ Survey Items	Scoring	VHA Average	Health- care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.9	4.9	4.6	4.2	4.4	4.5
All Employee Survey: <i>Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.5	4.4	3.9	3.8	4.2

Questions/ Survey Items	Scoring	VHA Average	Health- care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?</i>	0 (Never)– 6 (Every Day)	1.4	1.4	0.7	1.2	0.6	0.6	1.5

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.”<sup>22</sup> 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.<sup>23</sup>

The Director reported implementing strategies from VA’s “Stand Up to Stop Harassment Now!” campaign.<sup>24</sup> The Director discussed a commitment to a culture of safety and reported giving extensive presentations on the campaign during bi-monthly supervisor meetings. The Director also reported encouraging employees to speak up during all employee town hall meetings, and acknowledged believing that these efforts contributed to an increase in alternate disruptive resolutions and mediations. Further, the Director reported meeting with Lesbian, Gay, Bisexual and Transgender Program members and providing reassurance that all employees would be held accountable if issues occur.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA’s All Employee Survey responses. The healthcare system and executive leadership team averages for the selected survey questions were similar to or better than the VHA averages. Leaders

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<sup>22</sup> “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.

<sup>23</sup> “Stand Up to Stop Harassment Now!”

<sup>24</sup> Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*.

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	Health- care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>People treat each other with respect in my workgroup.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.9	4.0	4.4	4.7	3.8	4.4	4.2
All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	4.1	4.1	4.9	4.6	4.6	4.4	4.7
All Employee Survey: <i>Members in my workgroup are able to bring up problems and tough issues.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.2	4.6	3.6	4.1	4.3

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

## Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences.

Table 6 provides relevant survey results for VHA and the Orlando VA Healthcare System.<sup>25</sup> For this healthcare system, the overall patient satisfaction survey results generally reflected similar or higher care ratings than VHA averages. 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	Healthcare System Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	69.5	82.2
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	82.5	81.5
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	84.8	84.9

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.<sup>26</sup> 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 scores for male respondents were higher than VHA averages for inpatient care but similar to or lower than VHA averages for outpatient care. Respondents’ scores for access to urgently needed primary and specialty care appointments were generally lower than VHA averages. System leaders appeared to be actively engaged with male

<sup>25</sup> Ratings are based on responses by patients who received care at this healthcare system.

<sup>26</sup> “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](https://www.va.gov/vetdata/Veteran_Population.asp).



and female patients. For example, leaders reported developing a centralized call center, addressing veterans' feedback related to the environment, and conducting leadership rounds.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>Would you recommend this hospital to your friends and family?</i>	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	82.9	74.1
<i>During this hospital stay, how often did doctors treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	88.5	83.6
<i>During this hospital stay, how often did nurses treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	88.9	84.0

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 healthcare system averages are based on 517–524 male and 45 or 46 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	51.8	36.7
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	57.5	51.7
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	72.2	73.0

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 20, 2021).

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

†The healthcare system averages are based on 781–2,149 male and 95–186 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*		Healthcare System †	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	46.7	44.7
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	57.0	56.4
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	74.4	70.0

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 20, 2021).

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

†The healthcare system averages are based on 964–2,725 male and 46–148 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.<sup>27</sup> Table 10 summarizes the relevant healthcare system inspections most recently performed by the OIG and

<sup>27</sup> “Profile Definitions and Methodology: Joint Commission Accreditation,” American Hospital Directory, accessed December 12, 2020, [https://www.ahd.com/definitions/prof\\_accred.html](https://www.ahd.com/definitions/prof_accred.html). “The Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.”

The Joint Commission (TJC).<sup>28</sup> At the time of the OIG review, the healthcare system had closed all recommendations for improvement issued since the previous Clinical Assessment Program site visit conducted in November 2016.

The OIG team also noted the healthcare system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.<sup>29</sup> Additional results included the Long Term Care Institute's inspection of the healthcare system's CLC and the Paralyzed Veterans of America's inspection of the facility's spinal cord injury/disease unit and related services.<sup>30</sup>

**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 ( <i>Clinical Assessment Program Review of the Orlando VA Medical Center, Orlando, Florida, Report No. 16-00565-154, April 13, 2017</i> )	November 2016	12	0
OIG ( <i>Delays in Processing Community-Based Patient Care at the Orlando VA Medical Center, Florida, Report No. 18-01766-78, February 20, 2019</i> )	March 2018	6	0

<sup>28</sup> 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."

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

<sup>30</sup> "About Us," Long Term Care Institute, accessed December 8, 2020, <http://www.ltcior.org/about-us/>. The Long-Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings." The Paralyzed Veterans of America inspection took place on April 4, 2017. This veterans service organization's review does not result in accreditation status.

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG ( <i>Concerns Related to the Management of a Patient's Medication at Three VA Medical Centers and Inaccurate Response to a Congressional Inquiry at the VA Illiana Health Care System, Orlando Florida, Indianapolis, Indiana, Danville, Illinois, Report No. 18-02056-54, January 16, 2019</i> )	–	2*	0
TJC Hospital Accreditation	February 2018	32	0
TJC Behavioral Health Care Accreditation		3	0
TJC Home Care Accreditation		0	0

Source: OIG and TJC (inspection/survey results received from the Quality Manager Specialist on March 22, 2021).

\*There were eight total recommendations listed in this OIG report. The recommendations were assigned as follows: Orlando VA had two recommendations, Indianapolis VA had two recommendations, and Danville VA had the remaining four recommendations.

## Identified Factors Related to Possible Lapses in Care and Healthcare System Responses

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

Table 11 lists the reported patient safety events from December 3, 2016, through March 21, 2021.<sup>31</sup>

**Table 11. Summary of Selected Organizational Risk Factors  
(December 3, 2016, through March 21, 2021)**

Factor	Number of Occurrences
Sentinel Events	4
Institutional Disclosures	28
Large-Scale Disclosures	0

*Source: Orlando VA Healthcare System's Patient Safety Manager (received March 22, 2021), and the Risk Manager (received/confirmed March 23, 2021). VA OIG Management and Program Analyst sentinel event list (pulled February 22, 2021).*

The Director spoke knowledgeably about serious adverse event reporting, stating that all adverse events are reported to the Director as soon as possible. The Director reported that quality management staff and members of the executive leadership team review sentinel events and quality management staff seek guidance from VISN leaders when needed. The Director discussed the Risk Manager's role in the institutional disclosure process; the Risk Manager consults with the Chief of Staff or Deputy Chief of Staff prior to a disclosure with the patient or caregiver to ensure the information is consistent with the event and that the healthcare system takes responsibility. Further, the system's process for serious event follow-up is monitored through meetings between quality management staff and the executive leadership team.

The OIG noted concerns with staff identifying sentinel events and conducting institutional disclosures for those events. The OIG requested a list of the system's sentinel events and institutional disclosures conducted from December 3, 2016, through March 21, 2021. Quality

<sup>31</sup> 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 Orlando VA Healthcare System is a highest complexity (1a) affiliated system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

management staff provided the OIG team with four sentinel events and 28 institutional disclosures. For three of the sentinel events, root cause analyses were completed, and actions were implemented to mitigate future risks. For the fourth sentinel event, quality management staff had not determined if a root cause analysis would need to be conducted.

The OIG also reviewed the 28 institutional disclosures and identified that four adverse events may have met criteria for a sentinel event: two patients sustained an injury during a surgical procedure, one patient required additional care because of a medication error, and one patient died from complications after a fall.

## **Veterans Health Administration Performance Data for the Healthcare Systems**

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.”<sup>32</sup> 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.<sup>33</sup>

Figure 5 illustrates the healthcare system’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2020. Figure 5 shows the Orlando VA Healthcare System’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 stress discussed, care transition, mental health (MH) continuity (of) care, and MH population (popu) coverage). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, emergency department (ED) throughput, rating (of) specialty care (SC) provider, and MH experience (exp) of care).<sup>34</sup>

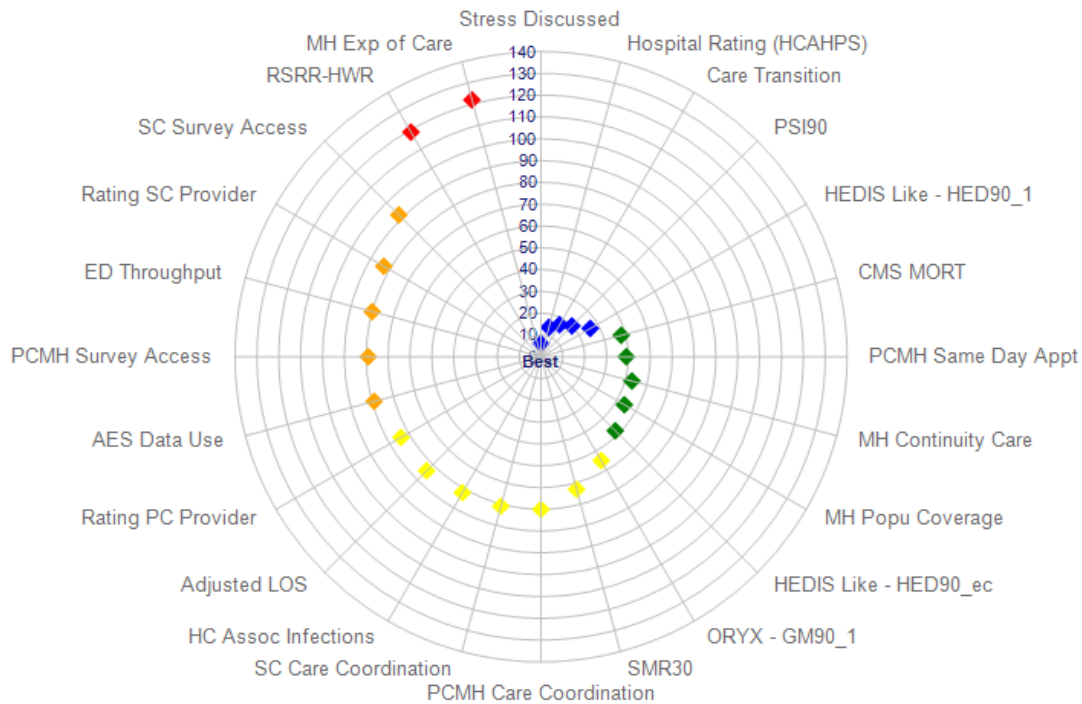
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<sup>32</sup> “Strategic Analytics for Improvement and Learning (SAIL) Value Model,” VHA Support Service Center, accessed on March 6, 2020, <https://vaww.vssc.med.va.gov>. (This is an internal website not publicly accessible.)

<sup>33</sup> “Strategic Analytics for Improvement and Learning (SAIL) Value Model.”

<sup>34</sup> 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.** System quality of care and efficiency metric rankings for FY 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

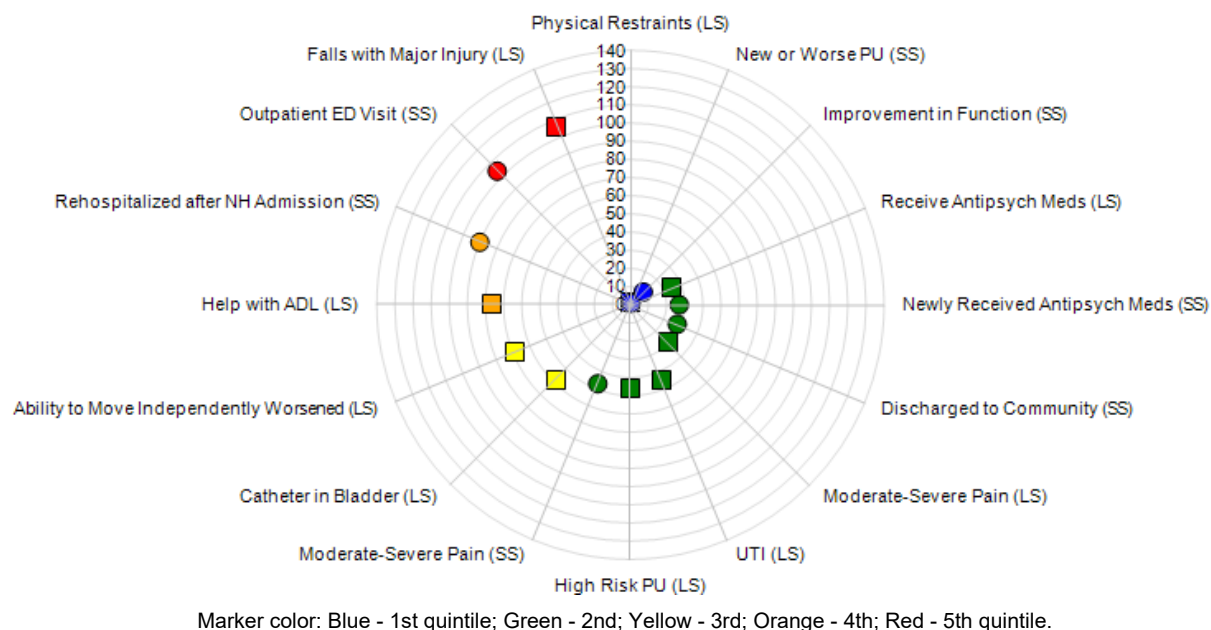
The CLC SAIL Value Model is a tool to “summarize and compare performance of CLCs in the VA.”<sup>35</sup> The model “leverages much of the same data” used in the Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare* and provides a single resource “to review quality measures and health inspection results.”<sup>36</sup>

<sup>35</sup> 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.

<sup>36</sup> 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.”



Figure 6 illustrates the healthcare system’s CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the Orlando VA Healthcare System’s CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of physical restraints–long-stay (LS), discharged to community–short-stay (SS), and high risk pressure ulcer (PU) (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, help with activities of daily living (ADL) (LS) and falls with major injury (LS)).<sup>37</sup>



**Figure 6.** Orlando VA Healthcare System CLC quality measure rankings for FY 2020 quarter 3 (as of June 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 team conducted this inspection, the healthcare system’s leaders had worked together for approximately two months, although all but one leader had served in their position for over a year. Two of the five executive leader positions were filled in an acting capacity.

The Director described the effect of an increased FY 2020 budget, and executive leaders were able to discuss interim strategies to address clinical occupational shortages.

<sup>37</sup> For data definitions of acronyms in the SAIL CLC measures, please see appendix F.

Selected employee satisfaction survey responses demonstrated satisfaction with leadership and maintenance of an environment where staff felt respected and discrimination was not tolerated. The OIG found that male respondents' survey scores were higher than VHA averages for inpatient care experience but similar to or lower than VHA averages for outpatient care. Respondents' scores for access to urgently needed primary or specialty care appointments were generally lower than VHA national averages.

The OIG's review of the system's accreditation findings did not identify any substantial organizational risk factors, and the system maintains its accreditation with TJC. However, the OIG noted concerns with staff identifying sentinel events and conducting institutional disclosures for those events.

Leaders were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. The executive leaders were also knowledgeable within their scope of responsibilities about selected VHA data used by SAIL and CLC SAIL models but should focus on strategies for continuous improvement.

## 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.<sup>38</sup> 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.<sup>39</sup>

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.”<sup>40</sup> “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.”<sup>41</sup>

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 healthcare system 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 healthcare system 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 healthcare system 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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<sup>38</sup> “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>.

<sup>39</sup> VHA Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

<sup>40</sup> 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.”

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

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 healthcare system'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 healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."<sup>45</sup> 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."<sup>46</sup> 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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<sup>42</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

<sup>43</sup> VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

<sup>44</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

<sup>45</sup> VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

<sup>46</sup> VHA Directive 1026.01.

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

Finally, the OIG assessed the healthcare system'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."<sup>52</sup> 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 development; (3) Data stewardship; and (4) Fiduciary responsibility for select

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<sup>47</sup> 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."

<sup>48</sup> VHA Directive 1190.

<sup>49</sup> VHA Directive 1190.

<sup>50</sup> VHA Directive 1190.

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

<sup>52</sup> "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, <https://dvagov.sharepoint.com/sites/VHANSOVASQIP/SitePages/Default.aspx>. (This is an internal VA website not publicly accessible.)

specialty programs.”<sup>53</sup> The healthcare system’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<sup>54</sup>

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.<sup>55</sup>

## **Quality, Safety, and Value Findings and Recommendations**

The healthcare system complied with requirements for a committee responsible for QSV oversight functions. However, the OIG identified an opportunity for improvement with the surgical work group process.

VHA requires medical center directors to ensure that facilities have a surgical work group that meets monthly. This work group must be chaired by the Chief of Surgery and include the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.<sup>56</sup> The OIG reviewed the surgical work group (locally referred to as the Facility Surgical Workgroup) meeting minutes from March 2020 through February 2021 and found that the Chief of Staff did not attend 3 of 12 meetings (25 percent). The lack of Chief of Staff involvement resulted in the review and analysis of surgery program data without the perspectives of a key staff member. The Chief of Staff reported that competing priorities related to the COVID-19 pandemic contributed to inconsistent attendance.

### **Recommendation 1**

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures that the Chief of Staff regularly attends Facility Surgical Workgroup meetings.

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<sup>53</sup> “NSO Reporting, Resources, & Tools.”

<sup>54</sup> VHA Directive 1102.01(1), *National Surgery Office*, April 4, 2019, amended May 22, 2019.

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

<sup>56</sup> VHA Directive 1102.01(1).

Healthcare system concurred.

Target date for completion: February 28, 2022

Healthcare system response: The System Director evaluated and determined there were no additional reasons for noncompliance. The lack of Chief of Staff attendance discovered by the Office of Inspector General was due to the Chief of Staff functioning as the Incident Command Center Commander due to the COVID-19 pandemic. The Deputy Chief of Staff, who has clinical duties and Surgery Service oversight attended on behalf of the Chief of Staff as next in the chain of command, however, there was no delegation of authority memo issued. Effective April 2021, a delegation of authority memo will be sent to the Facility Surgical Workgroup and captured in the minutes when there is an acting Chief of Staff. The Chief of Staff has consistently attended all Facility Surgical Workgroup meetings from March to July 2021 and had a delegation of authority memo that indicated an acting Chief of Staff was in attendance for the August 2021 meeting. A target of 90% or greater compliance was achieved for six consecutive months from March to August 2021. The Facility Surgical Workgroup meeting attendance will continue to be monitored for six consecutive months by the recorder or designee to ensure sustainment of 90% or greater compliance for each required member and reported to the Quality, Safety, Value Committee monthly for sustainment monitoring. The Facility Surgical Workgroup will report compliance to the Medical Executive Committee quarterly.

## 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.”<sup>57</sup> 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.”<sup>58</sup>

VA requires all RNs to hold at least one active, unencumbered license.<sup>59</sup> 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.<sup>60</sup> 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.<sup>61</sup> 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.<sup>62</sup>

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 282 RNs hired from January 1, 2020, through February 15, 2021. The OIG determined whether

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

The OIG also reviewed credentialing files for 30 of the 282 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

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<sup>57</sup> VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

<sup>58</sup> VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

<sup>59</sup> 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.”

<sup>60</sup> 38 U.S.C. § 7402.

<sup>61</sup> VHA Directive 2012-030.

<sup>62</sup> VHA Directive 2012-030.



## Registered Nurse Credentialing Findings and Recommendations

The OIG found the RNs were free from potentially disqualifying licensure actions but also identified a vulnerability with primary source verification.

VHA requires all current and previously held licenses to be verified from primary sources prior to an individual's initial appointment or transfer from another medical facility.<sup>63</sup> The OIG found that five RN credentialing files did not have evidence of primary source verification for each license held. This could have led to inappropriate hiring of nurses that could subsequently affect the provision of quality care. The Credentialing and Privileging Supervisor and Lead Dependent Credentialer reported that the increased workload from the COVID-19 pandemic affected new staff training and resulted in a lack of available credentialing staff to perform primary source verifications properly. Additionally, the Chief of Staff reported difficulties with the system's hiring actions due to the Human Resource Service centralizing under the VISN.

### Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and ensures that credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.

Healthcare system concurred.

Target date for completion: March 18, 2022

Healthcare system response: The System Director evaluated and determined there were no additional reasons for noncompliance. In April 2021, the Credentialing and Privileging Supervisor and Lead Dependent Credentialer implemented a quality check process to ensure all licenses held by a Registered Nurse (RN) are primary source verified prior to initial appointment or transfer from another facility. The Credentialing and Privileging Supervisor or designee will conduct a quarterly random audit of 30 RNs hired, or 100% if less than 30, from the prior quarter. The VetPro file will be reviewed to ensure all licenses held were verified prior to initial appointment. The audits will begin with fiscal year 2021 quarter three. Once the target compliance of 90% or greater is achieved, the Credentialing and Privileging Supervisor or designee will continue to conduct the audits for two consecutive quarters and report to the Quality, Safety, Value Committee quarterly for sustainment monitoring. The Quality, Safety, Value Committee will then report compliance to the Executive Leadership Committee quarterly.

<sup>63</sup> VHA Directive 2012-030.

## Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.<sup>64</sup> 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.<sup>65</sup>

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.<sup>66</sup> 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.<sup>67</sup>

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."<sup>68</sup> The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.<sup>69</sup>

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 49 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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<sup>64</sup> 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.

<sup>65</sup> Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

<sup>66</sup> Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*, May 8, 2020.

<sup>67</sup> 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*.

<sup>68</sup> 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.

<sup>69</sup> 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)<sup>70</sup>
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)<sup>71</sup>
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

## Medication Management Findings and Recommendations

The OIG found compliance with many of the indicators 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 a deficiency with the provision of patient/caregiver education.

At the time of the review, 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 or caregivers that remdesivir was not an FDA-approved medication; provide the option to refuse the medication; and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.<sup>72</sup> Of the 49 patients who received remdesivir, the OIG did not find evidence that providers informed 31 percent of those patients or their caregivers of the option to refuse remdesivir prior to administration. This could have resulted in the patient or caregiver lacking the information needed to make a fully informed decision on receiving the medication. The Chief of Infectious Disease reported that providers did not consistently document all elements of the fact sheet due to unexpected, urgent clinical circumstances. In addition, the Chief of Staff reported that remdesivir administration involved a provider speaking with the patient regarding risks and benefits of remdesivir,

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<sup>70</sup> “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.”

<sup>71</sup> “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.

<sup>72</sup> VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

reviewing the contents of the FDA fact sheet, and advising on the option to accept or refuse treatment.

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.<sup>73</sup>

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<sup>73</sup> Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19."

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.<sup>74</sup> 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.<sup>75</sup> However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.<sup>76</sup>

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.<sup>77</sup> 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.<sup>78</sup> The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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<sup>74</sup> “Suicide Prevention: Facts About Suicide,” Centers for Disease Control and Prevention, accessed December 9, 2020, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

<sup>75</sup> Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.

<sup>76</sup> Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.

<sup>77</sup> 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.

<sup>78</sup> DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

- the electronic health records of 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**

Generally, the healthcare system met the above requirements. 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.<sup>79</sup>

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.”<sup>80</sup> 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.<sup>81</sup>

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

## Care Coordination Findings and Recommendations

Generally, the healthcare system met expectations for an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, and nurse-to-nurse communication between facilities. However, the OIG noted a deficiency with staff sending advance directives to receiving facilities.

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<sup>79</sup> VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

<sup>80</sup> VHA Directive 1094.

<sup>81</sup> 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.

VHA requires that the Chief of Staff and ADPCS ensure transferring physicians or the assigned designees “send all pertinent medical records available, including...documentation of the patient’s advance directive made prior to transfer, if any” to the receiving facility.<sup>82</sup> Of the 17 patients who had an advanced directive, the OIG estimated that physicians did not send a copy of the directive to the receiving facility for 12 percent of those transfers.<sup>83</sup> 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.<sup>84</sup> The Emergency Department Section Chief reported that transferring providers were unaware of the requirement to send the patient’s advanced directive to the receiving facility. Due to the low number of patients identified with advance directives, the OIG made no recommendation.

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<sup>82</sup> VHA Directive 1094.

<sup>83</sup> The OIG estimated that 95 percent of the time, the true compliance rate is between 0.0 and 29.4, which is statistically significantly below the 90 percent benchmark.

<sup>84</sup> 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.”<sup>85</sup> 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.”<sup>86</sup> 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<sup>87</sup>
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings<sup>88</sup>
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction<sup>89</sup>
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants<sup>90</sup>

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<sup>85</sup> VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

<sup>86</sup> VHA Directive 2012-026.

<sup>87</sup> 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.”

<sup>88</sup> 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.”

<sup>89</sup> 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.”

<sup>90</sup> 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.<sup>91</sup> VHA also requires that employee threat assessment team members complete the appropriate team-specific training.<sup>92</sup> 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 determined that the healthcare system addressed many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with Disruptive Behavior Committee meeting attendance and staff training.

VHA requires that the Chief of Staff and Nurse Executive (ADPCS) be responsible for establishing a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; a patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and Union Safety Committee.<sup>93</sup>

The OIG found that the Disruptive Behavior Committee held 12 meetings from April 2020 through March 2021. Administrative support staff did not attend any of the meetings. Additionally, the Prevention and Management of Disruptive Behavior Program Manager did not attend four meetings (33 percent) and the Patient Advocate did not attend seven meetings (58 percent). This could result in a lack of knowledge and expertise when assessing patients' disruptive behavior. The Chair of the Disruptive Behavior Committee reported being unaware that administrative support staff were required to attend the meetings due to conflicting information received from the VISN. Additionally, the Chair cited COVID-19 pandemic-related staffing shortages as the reason for poor attendance by the Prevention and Management of Disruptive Behavior Program Manager and Patient Advocate.

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<sup>91</sup> DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

<sup>92</sup> DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

<sup>93</sup> VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

### Recommendation 3

3. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure all required representatives attend Disruptive Behavior Committee meetings.

Healthcare system concurred.

Target date for completion: March 18, 2022

Healthcare system response: The Chief of Staff and Associate Director for Patient Care Services evaluated and determined there were no additional reasons for noncompliance. In April 2021, a required member representative was changed to ensure committee attendance, and the required administrative support member was added. A target of 90% or greater compliance was achieved for six consecutive months from April to September 2021. The Disruptive Behavior Committee Chair or designee will continue to monitor attendance using an attendance log for required members for two consecutive quarters to ensure sustainment and report compliance to the Medical Executive Committee quarterly.

VHA requires that staff are assigned part 1 of the prevention and management of disruptive behavior training at hire and additional levels of training (parts 2 and 3), based on the risk level assigned to their work area.<sup>94</sup> The OIG found that 23 of 30 (77 percent) selected staff did not complete the required training based on the work area's risk level. This could result in lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Program Manager reported that parts 2 and 3 trainings require face-to-face contact and were put on hold due to the COVID-19 pandemic.

### Recommendation 4

4. The System Director evaluates and determines any additional reasons for noncompliance and ensures that staff complete the required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

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<sup>94</sup> DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*.

Healthcare system concurred.

Target date for completion: March 18, 2022

Healthcare system response: Prior to the COVID-19 pandemic, the Orlando VA Healthcare System sustained 100% compliance with Prevention and Management of Disruptive Behavior training parts two and three. In 2018, Orlando VA Healthcare System incorporated Prevention and Management of Disruptive Behavior training parts two and three in new employee orientation and it was cited as a best practice. When the COVID-19 pandemic started in 2020 all face-to-face trainings including new employee orientation were suspended. On April 3, 2020, the VHA Chief Learning Officer issued a 120-day moratorium for all non-COVID-19 mandatory or required training to be suspended with a recommendation to VA Medical Centers to exercise discretion with non-COVID-19 trainings. In December 2020, the Prevention and Management of Disruptive Behavior National Office recommended that Prevention and Management of Disruptive Behavior Managers, executive leadership teams, and facility COVID-19 experts to consider suspending any in-person training except for work areas with the highest risk. In May 2021, based on local infection rate data, the Orlando VA Healthcare System Incident Command Center Medical Branch determined it was safe to resume limited face-to-face trainings including Prevention and Management of Disruptive Behavior training parts two and three. However, due to the resurgence of COVID-19 in July 2021 all face-to-face trainings were suspended. Newly hired employees will now receive Prevention and Management of Disruptive Behavior part two and part three training whose work area is identified as the highest risk with one-to-one training to allow for social distancing. A review to determine resuming all face-to-face trainings will occur in October 2021.

At the time the Orlando VA Healthcare System can resume all face-to-face trainings, the Prevention and Management of Disruptive Behavior Program Manager or designee will track parts two and three training compliance for new employees. Quarterly Talent Management System reports will be run to determine compliance for new employees until a target compliance rate of 90% or greater is achieved. Once targets are achieved for new employees, the Prevention and Management of Disruptive Behavior Program Manager or designee will continue to track parts two and three trainings required for new employees based on their assigned workplace. This tracking will continue for six consecutive months to ensure sustainment of compliance and reported to the Quality, Safety, Value Committee monthly to monitor compliance. The Quality, Safety, Value Committee will then report compliance to the Medical Executive Committee quarterly.

## **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 healthcare system, the OIG conducted a detailed review of eight clinical and administrative areas and provided four 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 healthcare system, 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 four 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	<ul style="list-style-type: none"> <li>Executive leadership position stability and engagement</li> <li>Budget and operations</li> <li>Staffing</li> <li>Employee satisfaction</li> <li>Patient experience</li> <li>Accreditation surveys and oversight inspections</li> <li>Identified factors related to possible lapses in care and healthcare system response</li> <li>VHA performance data (healthcare system)</li> <li>VHA performance data (CLC)</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
COVID-19 Pandemic Readiness and Response	<ul style="list-style-type: none"> <li>Emergency preparedness</li> <li>Supplies, equipment, and infrastructure</li> <li>Staffing</li> <li>Access to care</li> <li>CLC patient care and operations</li> <li>Staff feedback</li> </ul>	The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system 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	<ul style="list-style-type: none"> <li>• QSV committee</li> <li>• Systems redesign and improvement</li> <li>• Protected peer reviews</li> <li>• Surgical program</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• The Chief of Staff attends Facility Surgical Workgroup meetings.</li> </ul>
RN Credentialing	<ul style="list-style-type: none"> <li>• RN licensure requirements</li> <li>• Primary source verification</li> </ul>	<ul style="list-style-type: none"> <li>• Credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Medication Management: Remdesivir Use in VHA	<ul style="list-style-type: none"> <li>• Staff availability for medication shipment receipt</li> <li>• Medication order naming</li> <li>• Satisfaction of inclusion criteria prior to medication administration</li> <li>• Required testing prior to medication administration</li> <li>• Patient/caregiver education</li> <li>• Adverse event reporting to the FDA</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	<ul style="list-style-type: none"> <li>• Columbia-Suicide Severity Rating Scale initiation and note completion</li> <li>• Suicide safety plan completion</li> <li>• Staff training requirements</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	<ul style="list-style-type: none"> <li>• Inter-facility transfer policy</li> <li>• Inter-facility transfer monitoring and evaluation</li> <li>• Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer</li> <li>• Patient's active medication list and advance directive sent to receiving facility</li> <li>• Communication between nurses at sending and receiving facilities</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
High-Risk Processes: Management of Disruptive and Violent Behavior	<ul style="list-style-type: none"> <li>• Policy for reporting and tracking of disruptive behavior</li> <li>• Employee threat assessment team implementation</li> <li>• Disruptive behavior committee or board establishment</li> <li>• Disruptive Behavior Reporting System use</li> <li>• Patient notification of an Order of Behavioral Restriction</li> <li>• Annual Workplace Behavioral Risk Assessment with involvement from required participants</li> <li>• Mandatory staff training</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Required representatives attend Disruptive Behavior Committee meetings.</li> <li>• Staff complete the required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.</li> </ul>



## Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 8.<sup>1</sup>

**Table B.1. Profile for Orlando VA Healthcare System (675)  
(October 1, 2017, through September 30, 2020)**

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
Total medical care budget	\$872,418,387	\$912,022,613	\$1,140,292,102
Number of:	116,849	119,147	121,541
• Unique patients			
• Outpatient visits	1,702,547	1,714,797	1,594,770
• Unique employees§	3,586	3,669	3,990
Type and number of operating beds:	120	120	120
• Community living center			
• Domiciliary	116	116	116
• Medicine	59	59	59
• Mental health	40	40	40
• Surgery	35	35	35
Average daily census:	91	107	106
• Community living center			
• Domiciliary	106	103	60
• Intermediate	0	–	1
• Medicine	60	62	56

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

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
• Surgery	5	4	2

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 healthcare system 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.<sup>1</sup>

**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
Viera, FL	675GA	65,914	27,852	Allergy Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology General Surgery GYN Infectious disease Nephrology	EKG Laboratory & Pathology Nuclear med Radiology	Dental Nutrition Pharmacy Prosthetics Social work Weight management

<sup>1</sup> 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
Viera, FL (continued)				Neurology Orthopedics Otolaryngology Plastic Podiatry Rehab physician Rheumatology Spinal cord injury Urology		
Daytona Beach, FL	675GB	59,000	2,517	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology Nephrology Orthopedics Podiatry Rheumatology Urology	EKG Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Prosthetics Social work Weight management
Kissimmee, FL	675GC	13,992	3,589	Dermatology	–	–
Deltona, FL	675GD	14,298	5,225	Cardiology Dermatology	–	Nutrition Pharmacy Social work Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Tavares, FL	675GE	12,729	4,368	Cardiology Dermatology Nephrology	–	Nutrition Pharmacy Social work Weight management
Clermont, FL	675GF	10,623	1,892	Cardiology Dermatology Endocrinology	–	Nutrition Pharmacy Social work Weight management
Orlando, FL	675GG	58,787	24,632	Anesthesia Cardiology Endocrinology Eye Poly-Trauma Rehab physician Spinal cord injury	Laboratory & Pathology Radiology	Nutrition Pharmacy Prosthetics Social work Weight management
Daytona Beach, FL	675QC	–	18,479	–	–	Pharmacy Social work
Winter Park, FL	675QD	–	10,494	Poly-Trauma	–	Pharmacy
Palm Bay, FL	675QG	482	–	–	–	–

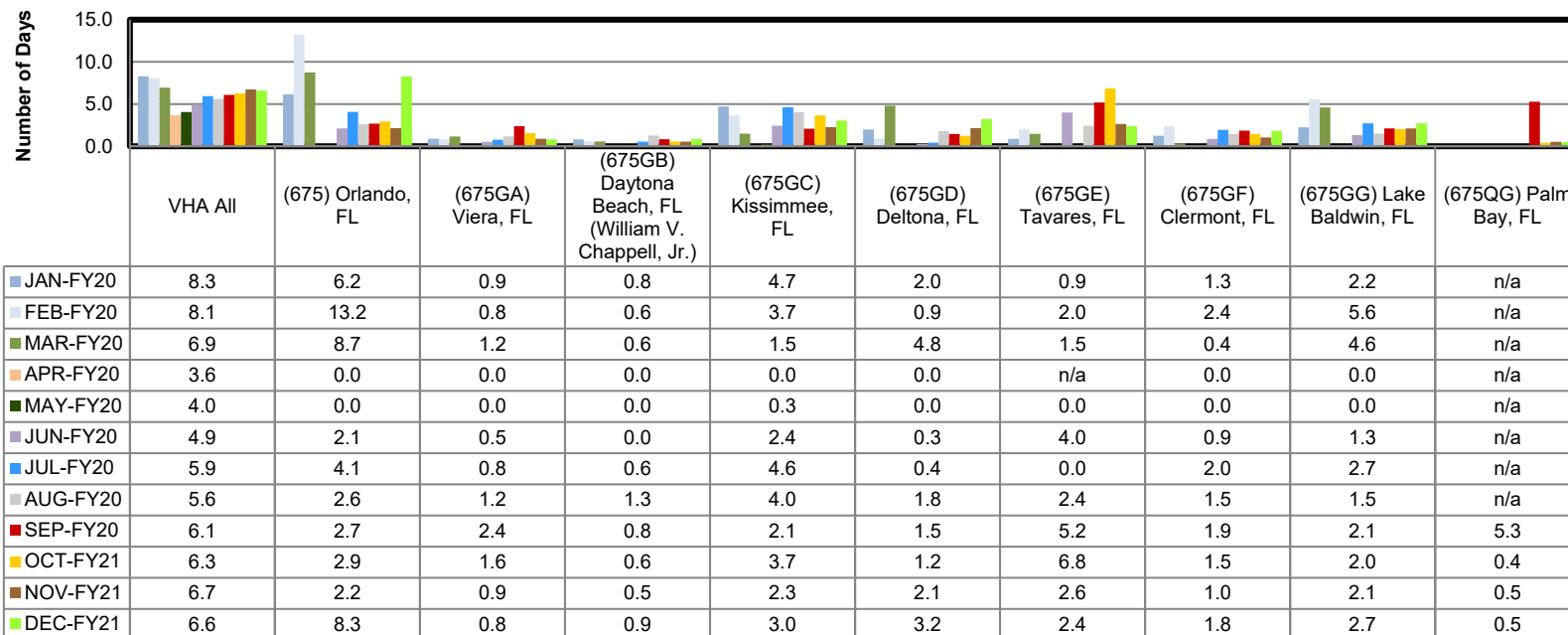
Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

The OIG omitted (675QB) Port Orange, FL, as no data were reported.

## Appendix D: Patient Aligned Care Team Compass Metrics

### Quarterly New Primary Care Patient Average Wait Time in Days

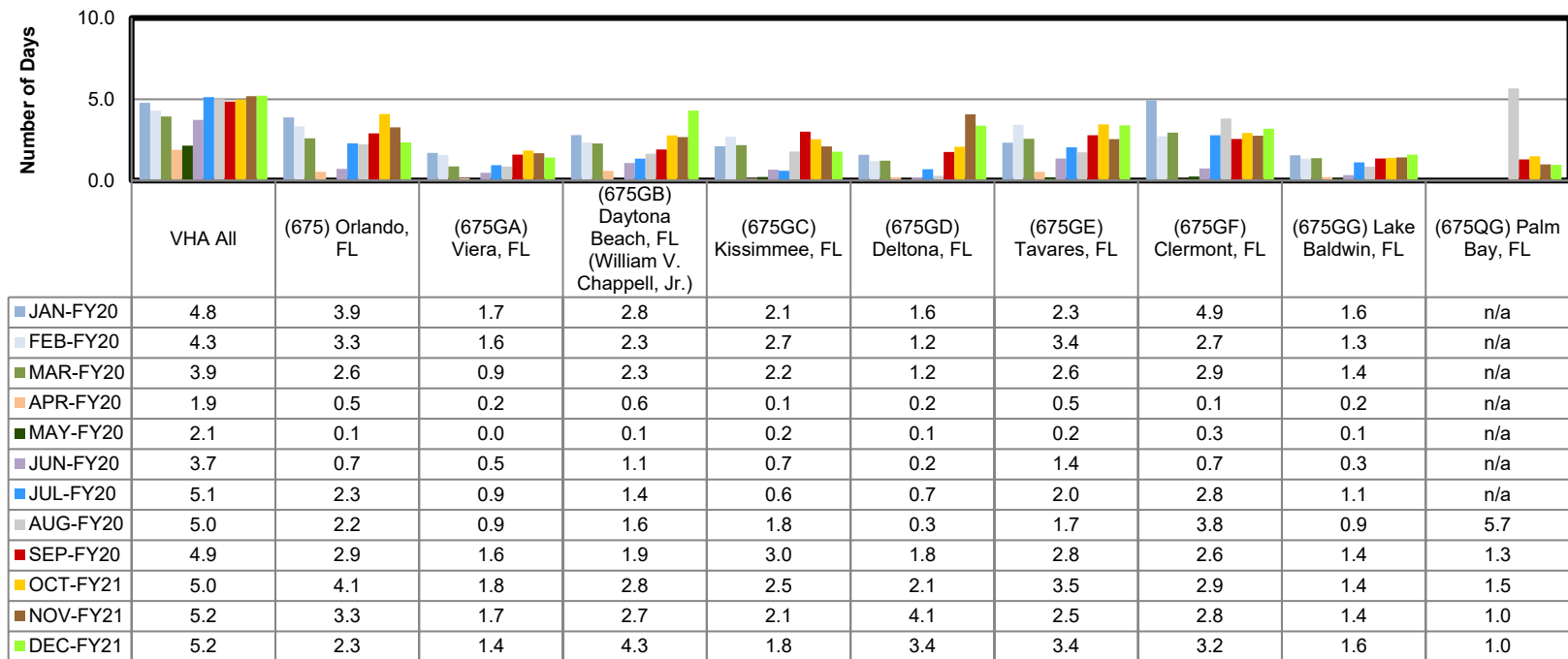


Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, <https://vssc.med.va.gov>, accessed October 21, 2019.

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (675QB) Port Orange, FL; (675QC) Westside Pavilion, FL; and (675QD) Crossroads, 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



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 (675QB) Port Orange, FL; (675QC) Westside Pavilion, FL; and (675QD) Crossroads, 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." The absence of reported data is indicated by "n/a."

## 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 med (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 med (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 17, 2021

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

Subj: Comprehensive Healthcare Inspection of the Orlando VA Healthcare System in Florida

To: Director, Office of Healthcare Inspections (54CH06)

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

I have reviewed the VAOIG's report as well as the Orlando VA Healthcare System's response and concur with the findings, recommendations, and action plans submitted therein.

*(Original signed by:)*

Miguel H Lapuz, M.D., MBA

Network Director, VISN 8

## **Appendix H: Healthcare System Director Comments**

### **Department of Veterans Affairs Memorandum**

Date: September 16, 2021

From: Director, Orlando VA Healthcare System (675/00)

Subj: Comprehensive Healthcare Inspection of the Orlando VA Healthcare System in Florida

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

I have reviewed the VA OIG's report of the Orlando VA Healthcare System, Orlando, Florida. I concur with the findings and recommendations contained therein.

*(Original signed by:)*

Timothy J Cooke

Medical Center Director

Orlando VA Healthcare System

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