DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 8: VA Sunshine Healthcare Network in St. Petersburg, Florida

CHIP REPORT | REPORT #21-00236-44 | JANUARY 12, 2022

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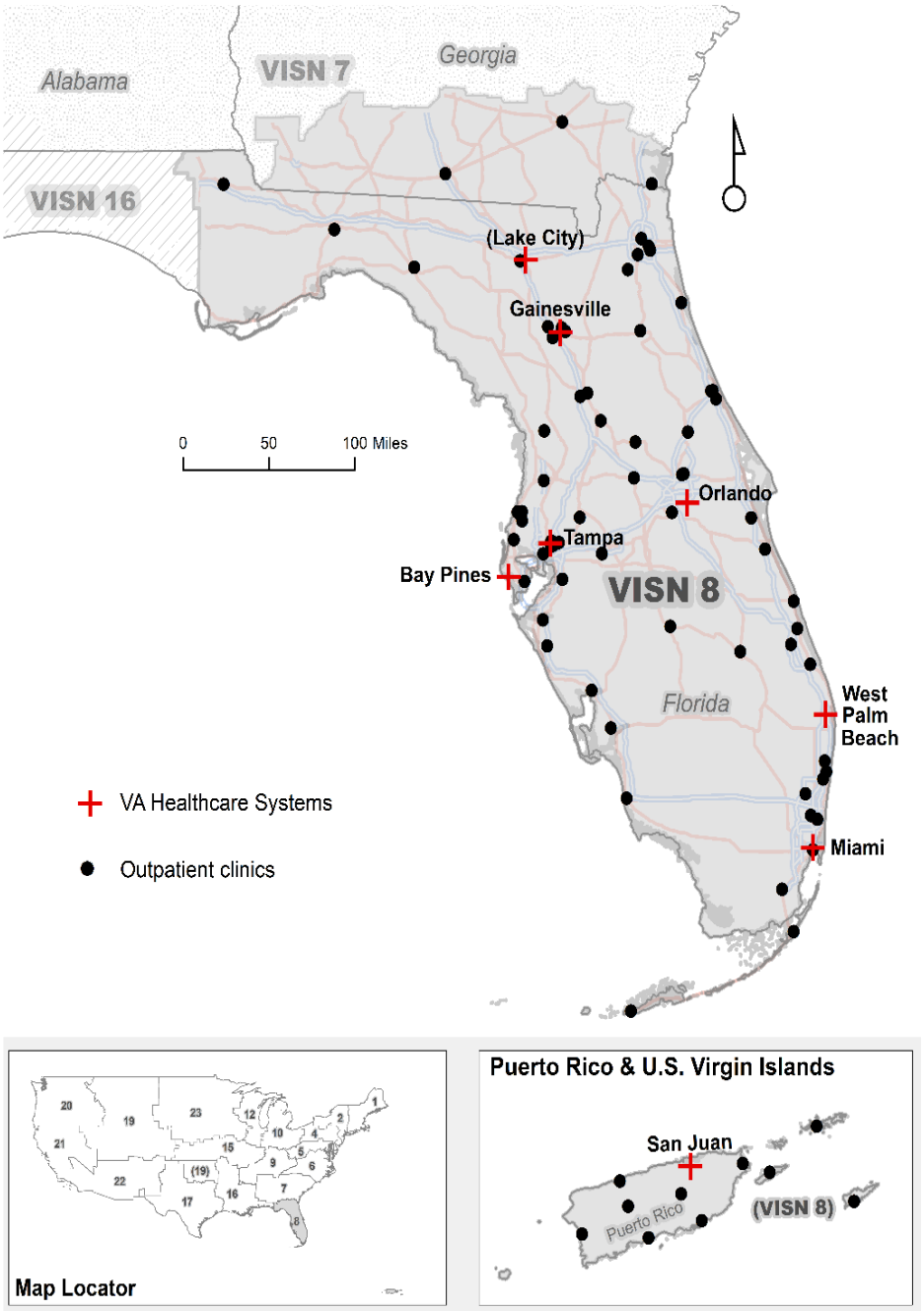

Figure 1. *Veterans Integrated Service Network 8: VA Sunshine Healthcare Network. Source: Veterans Affairs Site Tracking Database (accessed March 22, 2021).*

Abbreviations

CCC	Clinical Contact Center
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
CNO	chief nursing officer
ED	emergency department
FTE	full-time equivalent
FY	fiscal year
HCS	healthcare system or health care system
HRO	human resource officer
OIG	Office of Inspector General
QMO	quality management officer
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by Veterans Integrated Service Network (VISN) 8: VA Sunshine Healthcare Network in St. Petersburg, 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 OIG selects and evaluates specific areas of focus each year.

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

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Medical staff credentialing
4. Environment of care
5. Mental health (focusing on suicide prevention)
6. Care coordination (targeting inter-facility transfers)
7. Women's health (examining comprehensive care)

The OIG conducted this unannounced virtual review during the week of March 22, 2021. The OIG also performed virtual reviews of the following VISN 8 facilities during the weeks of March 15 and March 22, 2021:

- Bay Pines VA Healthcare System (Florida)
- James A. Haley Veterans' Hospital (Tampa, Florida)
- Miami VA Healthcare System (Florida)
- North Florida/South Georgia Veterans Health System (Gainesville, Florida)
- Orlando VA Healthcare System (Florida)
- VA Caribbean Healthcare System (San Juan, Puerto Rico)

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

- West Palm Beach VA Medical Center (Florida)

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. The findings presented in this report are a snapshot of VISN 8 and facility performance within the identified focus areas at the time of the OIG review. The findings in this report may help VISN leaders identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual review, the VISN leadership team consisted of the Network Director, Deputy Network Director for Operations, Chief Medical Officer, Quality Management Officer/Chief Nursing Officer, Deputy Director for Clinical Contact Center, Human Resource Officer, and Chief Financial Officer. The VISN managed organizational communication and accountability through a committee reporting structure. Within this structure, the VISN's Executive Leadership Council oversaw the Healthcare Delivery; Healthcare Operations; Organizational Health; Clinical Contact Center; and Quality, Safety, Value Committees.

The executive leadership team had worked together since May 2019. The longest tenured member was the Chief Financial Officer, who was assigned in 2008. The Network Director was assigned in 2016, while the Chief Medical Officer and Human Resource Officer had been in their roles since 2017. The Deputy Director for Clinical Contact Center arrived in 2018, and the Deputy Network Director for Operations and Quality Management Officer/Chief Nursing Officer were appointed in 2019.

The OIG reviewed selected employee satisfaction and patient experience survey results. The OIG concluded that VISN leaders were engaged and promoted a culture of safety where employees felt safe bringing forward issues and concerns. However, the Network Director had opportunities to improve servant leadership and employee attitudes toward the workplace.[2] The

[2] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The 2020 All Employee Survey defines the Servant Leader Index Composite as a summary measure based on respondents' assessments of their supervisors' listening, respect, favoritism, and response to concerns.

OIG found that selected patient experience survey scores were similar to or higher than Veterans Health Administration (VHA) averages. Patients were generally satisfied with the care provided.

The inspection team also evaluated VISN access metrics and clinical vacancies. The team identified potential organizational risks at select facilities that have extended wait times and clinical vacancies in certain specialties.

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[3] 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.[4]

Leaders were knowledgeable, within their scope of responsibilities, about selected SAIL and Community Living Center SAIL measures. However, the OIG identified that the Network Director, Chief Medical Officer, and Quality Management Officer/Chief Nursing Officer had opportunities to improve their oversight of facility-level quality, safety, and value; registered nurse credentialing; care coordination; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 8 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[5]

Medical Staff Credentialing

The OIG identified weaknesses in the review and approval of physicians who had potentially disqualifying licensure actions prior to their VA appointment.

Women's Health

The OIG observed compliance with the appointment of a lead women veterans program manager, establishment of a multidisciplinary team to execute strategic planning activities, monthly calls with facility women veterans program leaders, staff education gap assessments,

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

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

[5] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 1 and 8*, Report No. 21-02969-20, November 18, 2021.

access and satisfaction data analyses, and VISN-level support staff availability. However, the OIG found a deficiency with the completion of annual site visits at each facility.

Conclusion

The OIG conducted a detailed inspection across eight key areas and subsequently issued two recommendations for improvement to the Network Director and Chief Medical Officer. The number of recommendations should not be used as a gauge for the overall quality of care provided within this VISN. The intent is for VISN leaders to use these recommendations to help guide improvements in operations and clinical care throughout the network of assigned facilities. The recommendations address issues that may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix G, page 51, and the responses within the body of the report for the full text of the Network Director's comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 8: VA Sunshine Healthcare Network. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so they can make informed decisions to improve care.

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.[1] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[2]

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review and initiated a 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:[3]

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[4]
3. Quality, safety, and value (QSV)
4. Medical staff credentialing
5. Environment of care
6. Mental health (focusing on suicide prevention)
7. Care coordination (targeting inter-facility transfers)
8. Women's health (examining comprehensive care)

[1] 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.

[2] 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.

[3] 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.

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

Methodology

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

The inspection examined operations from October 22, 2016, through March 26, 2021, the last day of the unannounced multiday virtual review.[5]

The OIG also performed inspections of the following VISN 8 facilities during the weeks of March 15 and March 22, 2021:

- Bay Pines VA Healthcare System (HCS) (Florida)
- James A. Haley Veterans' Hospital (Tampa, Florida)
- Miami VA HCS (Florida)
- North Florida/South Georgia Veterans Health System (Gainesville, Florida)
- Orlando VA HCS (Florida)
- VA Caribbean HCS (San Juan, Puerto Rico)
- West Palm Beach VA Medical Center (VAMC) (Florida)

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 8 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[6]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[7] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VISN leaders complete corrective actions. The Network Director's responses to the report recommendations appear

[5] The range represents the time from the Clinical Assessment Program review of the VA Caribbean HCS to the completion of the unannounced multiday virtual CHIP visit on March 26, 2021 (see appendix D).
[6] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 1 and 8*, Report No. 21-02969-20, November 18, 2021.
[7] Pub. L., No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3).

within each topic area. The OIG accepted the action plans that VISN leaders developed based on the reasons for noncompliance.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can affect the ability to provide care in the clinical focus areas.[8] To assess this VISN's risks, the OIG considered the following indicators:

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

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility virtual CHIP visits performed during the weeks of March 15 and 22, 2021.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is the basic budgetary and planning unit of the veterans' healthcare system.[9]

Geographically, VISN 8 covers approximately 63,400 square miles throughout Florida, Southern Georgia, Puerto Rico, and the U.S. Virgin Islands. The VISN operated 8 medical centers and 65 outpatient clinics. According to data from the VA National Center for Veterans Analysis and Statistics, the VISN had a veteran population of 1,470,458 within its borders at the beginning of

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

[9] *The Curious Case of the VISN Takeover: Assessing VA's Governance Structure, Hearing Before the House Committee on Veterans' Affairs*, 115th Cong. (2018) (statement of Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration).

fiscal year (FY) 2021 and a projected FY 2022 population of 1,443,994. The medical care budget was $5,956,665,671 for FY 2019 and $7,103,013,544 for FY 2020.[10]

The OIG recognizes that the COVID-19 pandemic caused significant and widespread changes in the delivery of healthcare services.[11] As a result, productivity data and supporting reports may require further analysis to reach specific actionable conclusions.

VISN 8 had an executive leadership team consisting of the Network Director, Deputy Network Director for Operations, Chief Medical Officer (CMO), Quality Management Officer/Chief Nursing Officer (QMO/CNO), Human Resource Officer (HRO), Deputy Director for Clinical Contact Center (CCC), and Chief Financial Officer. The CMO and QMO/CNO oversaw facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.[12]

[10] "Veteran Population," National Center for Veterans Analysis and Statistics, Department of Veterans Affairs, accessed March 16, 2021, https://www.va.gov/vetdata/veteran_population.asp. "VSSC, Trip Pack – Operational Statistics Table, FY2019 through September," VHA Support Service Center, accessed February 18, 2021, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fMgmtReports%2fPocketCard%2fTripPack_OperationalStatisticsTable&rs:Command=Render. (This is an internal website not publicly accessible.)

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

[12] For this VISN, the Network Director is responsible for the directors of the Bay Pines VA HCS (Florida); James A. Haley Veterans' Hospital (Tampa, Florida); Miami VA HCS (Florida); North Florida/South Georgia Veterans Health System (Gainesville, Florida); Orlando HCS (Florida); VA Caribbean HCS (San Juan, Puerto Rico); and West Palm Beach VAMC (Florida).

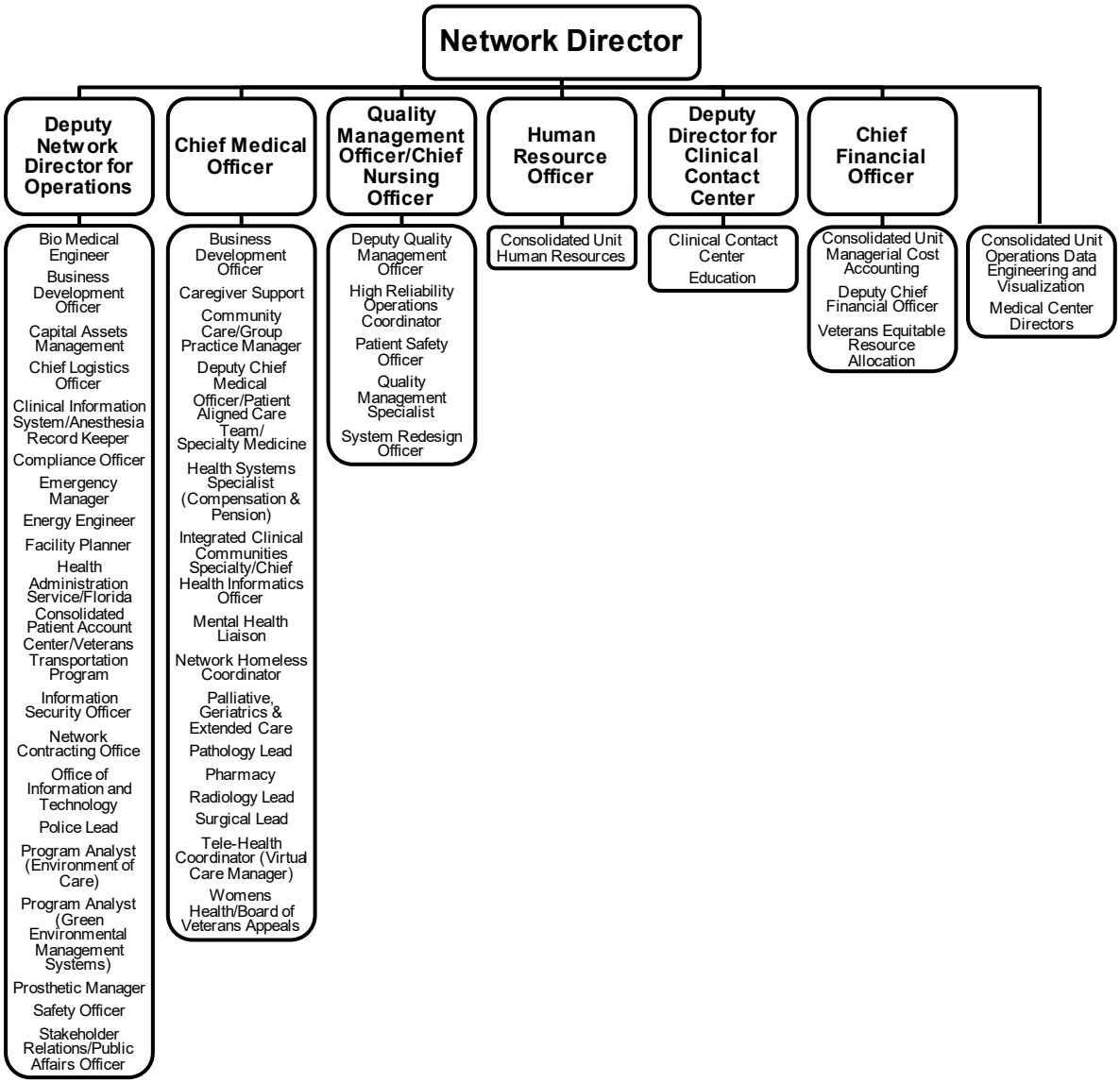


Figure 2. *VISN 8 organizational chart.*

Source: VA Sunshine Healthcare Network (received March 22, 2021).

At the time of the OIG virtual review, the VISN's leadership team had worked together since May 2019. The Chief Financial Officer, assigned in 2008, was the longest tenured member of the team. The Network Director was assigned in 2016, and the CMO and HRO had been on board since 2017. The Deputy Director for CCC arrived in 2018, and the Deputy Network Director for Operations and QMO/CNO were assigned in 2019 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	February 21, 2016
Deputy Network Director for Operations	May 12, 2019
Chief Medical Officer	November 26, 2017
Deputy Director for Clinical Contact Center	September 16, 2018
Quality Management Officer/Chief Nursing Officer	April 28, 2019
Human Resource Officer	January 22, 2017
Chief Financial Officer	September 28, 2008

Source: VA Sunshine Healthcare Network (received March 22, 2021).

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

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

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

- providing organizational values and strategic direction,
- developing policy and making decisions,
- managing compliance and financial performance,
- regularly reviewing organizational performance and capabilities,
- identifying priorities for improvement and opportunities for innovation, and
- developing and communicating organizational goals and objectives across the network.

The Network Director serves as the chairperson of the Executive Leadership Council, which had direct oversight of the CCC, Healthcare Delivery, Healthcare Operations, Organizational Health, and QSV committees (see figure 3).

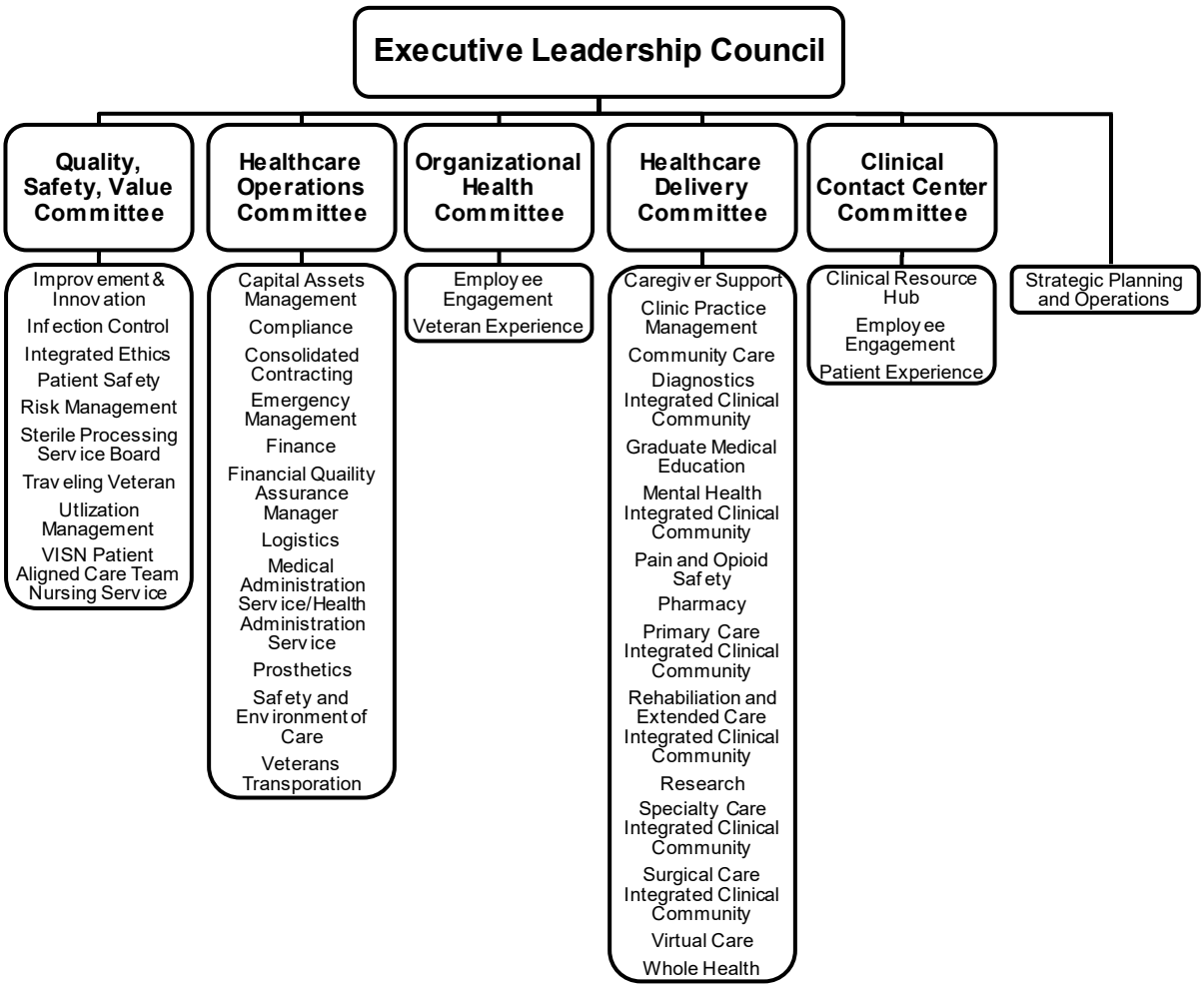


Figure 3. *VISN 8 committee reporting structure.*
Source: VA Sunshine Healthcare Network (received March 22, 2021).

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[14] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on VISN leaders.

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

To assess employee attitudes toward VISN leaders, the OIG reviewed VHA All Employee Survey satisfaction results from October 1, 2019, through September 30, 2020.[15] Table 2 summarizes those results. The OIG found the VISN office and leaders' average scores for the selected survey leadership questions were generally higher than VHA averages. However, the Network Director had opportunities to improve servant leadership. For FY 2020, leaders met with staff and the VISN Organizational Development Team to review scores to draft staff-inspired action plans.[16]

Table 2. Survey Results on Employee Attitudes toward VISN 8 Leaders (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	VISN 8 Office Average	Network Director Average	Deputy Network Director for Operations Average	CMO Average	Deputy Director for CCC Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where HIGHER scores are more favorable	73.8	81.9	70.0	91.0	96.0	93.9
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.5	4.1	3.8	4.5	4.9	4.7
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	4.2	3.8	4.5	4.9	4.9

[15] Ratings are based on responses by employees who report to or are aligned under the Network Director; Deputy Network Director for Operations; CMO; Deputy Director for CCC. The QMO/CNO did not have enough direct employee reports to calculate a score so staff were rolled into the Director's totals.

[16] 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.

Questions/Survey Items	Scoring	VHA Average	VISN 8 Office Average	Network Director Average	Deputy Network Director for Operations Average	CMO Average	Deputy Director for CCC Average
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.7	4.2	4.0	4.7	4.9	4.9

Source: VA All Employee Survey (accessed February 22 and September 20, 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 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The leaders' averages for employee attitudes toward the workplace were generally better than the VHA averages; however, the Network Director had opportunities to improve scores.

Table 3. Survey Results on Employee Attitudes toward the VISN 8 Workplace (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	VISN 8 Office Average	Network Director Average	Deputy Network Director for Operations Average	CMO Average	Deputy Director for CCC Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	4.2	3.7	4.7	4.8	4.7

Questions/Survey Items	Scoring	VHA Average	VISN 8 Office Average	Network Director Average	Deputy Network Director for Operations Average	CMO Average	Deputy Director for CCC Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	4.1	3.2	4.4	4.8	4.6
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)– 6 (Every Day) lower is better.	1.4	1.1	2.2	0.7	0.9	1.0

Source: VA All Employee Survey (accessed February 22 and September 20, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[17] 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 felt secure and respected.[18]

Table 4 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. Scores for VISN leaders were generally similar to or higher

[17] "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.

[18] "Stand Up to Stop Harassment Now!"

than the VHA averages. Leaders appeared to promote an environment where discrimination was not tolerated, and staff felt safe bringing up problems and tough issues.

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

Questions/Survey Items	Scoring	VHA Average	VISN 8 Office Average	Network Director Average	Deputy Network Director for Operations Average	CMO Average	Deputy Director for CCC Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.9	4.4	3.5	4.7	4.9	4.9
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.1	4.4	4.0	4.5	4.9	4.7
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues*.	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	4.2	3.7	4.7	4.8	4.7

Source: VA All Employee Survey (accessed February 22 and September 20, 2021).

Patient Experience

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 collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys.

The OIG reviewed survey responses to three relevant questions that reflect patients' attitudes toward their healthcare experiences from October 1, 2019, through September 30, 2020. Table 5

provides relevant survey results for VHA and VISN 8.[19] The VISN averages for the selected survey questions were higher than VHA averages for Inpatient and Patient-Centered Medical Home scores and slightly lower than VHA for Specialty Care scores. VISN 8 patients appeared as satisfied or more with their care than VHA patients in general.

VISN 8 facility scores for the selected survey questions can be found in appendix C. The OIG found that the VISN Veteran Experience Office tracked patient satisfaction scores and reported to the Executive Leadership Council. The VISN leaders were reportedly concerned about past patient satisfaction with cleanliness. In February 2020, the VISN hired an Environmental Management Service Chief who established a VISN 8 pilot for a national level Environmental Management dashboard to track issues and revised survey processes to assess patient satisfaction related to cleanliness issues and quickly respond to patients' immediate concerns (such as room cleaning, better meals, or trash removal).

Table 5. Survey Results on Patient Attitudes within VISN 8 (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA Average	VISN 8 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	75.0
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.5	82.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.8	84.3

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

Access to Care

A VA priority is achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans. VHA has a goal of providing patient care

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

appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[20] VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates.[21] Wait time measures based on "create date" have the advantage of not relying on the accuracy of the "preferred date" entered into the scheduling system; these measures are particularly applicable for new primary care patients where the care is not initiated by referral or consultation that includes a "clinically indicated date."[22] The disadvantage to "create date" metrics is that wait times do not account for specific patient requests or availability.[23] Wait time measures based on patient preferred dates consider patient preferences but rely on appointment schedulers accurately recording the patients' wishes into the scheduling software.[24]

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[25] However, with enactment of the VA MISSION Act on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[26]

- Average drive time
    - 30-minute average drive time for primary care, mental health, and noninstitutional extended care services
    - 60-minute average drive time for specialty care
- Appointment wait time

[20] VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. The "Clinically Indicated Date (CID) is the date an appointment that is deemed clinically appropriate by a VA healthcare provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

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

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

[23] Office of Veterans Access to Care, *Specialty Care Roadmap*.

[24] Office of Veterans Access to Care, *Specialty Care Roadmap*.

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

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

- 20 days for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with a VA healthcare provider
- 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA healthcare provider

To examine access to primary and mental health care within VISN 8, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 6 and 7 provide wait time statistics for completed appointments from September 30 through December 31, 2020.[27]

Table 6. Primary Care Appointment Wait Times (September 30 through December 31, 2020)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VISN 8	9,512	17.1
Bay Pines VA HCS (FL)	1,444	28.8
James A. Haley Veterans' Hospital (Tampa, FL)	1,389	11.1
Miami VA HCS (FL)	537	11.0
North Florida/South Georgia Veterans Health System (Gainesville)	2,377	19.1
Orlando VA HCS (FL)	2,587	14.9
VA Caribbean HCS (San Juan, PR)	462	1.8
West Palm Beach VAMC (FL)	716	7.4

Source: VHA Support Service Center (accessed February 22, 2021).

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

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

Table 7. Mental Health Appointment Wait Times (September 30 through December 31, 2020)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VISN 8	2,087	11.0
Bay Pines VA HCS (FL)	166	11.2
James A. Haley Veterans' Hospital (Tampa, FL)	333	11.6
Miami VA HCS (FL)	202	12.5
North Florida/South Georgia Veterans Health System (Gainesville)	356	17.2
Orlando VA HCS (FL)	740	8.8
VA Caribbean HCS (San Juan, PR)	135	3.7
West Palm Beach VAMC (FL)	155	9.3

Source: VHA Support Service Center (accessed February 22, 2021).

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

Based on wait times alone, the MISSION Act may improve access to primary care for patients in the Bay Pines VA HCS and North Florida/South Georgia Veterans Health System, where the average wait times for new primary care appointments were 28.8 and 19.1 days, respectively. The average mental health wait time for new patients was 11.0 days for the VISN overall; the longest facility wait time was 17.2 days at the North Florida/South Georgia Veterans Health System. The wait times also highlight opportunities for VISN 8 facilities to improve the timeliness of "in house" primary care and decrease the potential for fragmented care among patients referred to community providers.

VISN executive leaders regularly tracked wait times with the VISN's Integrated Care Dashboard, which displays current data for each VAMC or HCS. VISN leaders reported that higher wait times at the Bay Pines VA HCS and North Florida/South Georgia Veterans Health System were associated with rural clinics and difficulty recruiting staff to those areas. In February 2021, the Bay Pines VA HCS's new primary care appointment wait time decreased from 28.8 to 23.9 days. VISN leaders stated that this drop was likely due to increased primary care staff returning to outpatient duties from COVID-19 pandemic inpatient assignments.

To improve access to care, VISN leaders established the CCC in June 2019. It was expanded across the VISN and provided 24/7 access for veterans via telephone, video, and chat. The CCC was staffed by medical support assistants with specialized training in clinical and crisis contact, as well as licensed independent practitioners and pharmacists who provided remote care to veterans the same day or on the veterans' preferred schedule. The CCC had a standing committee on the VISN's Executive Leadership Council that reported regularly. In addition to triaging patients with potential COVID-19 and delivering virtual urgent care, the center staff assisted in

the VISN's COVID vaccine distribution efforts by scheduling over 12,000 first time doses for veterans.

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover—or instability—and high clinical vacancy rates negatively affect access to care, quality, patient safety, and patient and staff satisfaction. Turnover can reduce employee and organizational performance through the loss of experienced staff.[28]

To assess the extent of clinical vacancies across VISN 8 facilities, the OIG held discussions with the HRO and reviewed the total number of vacancies by facility, position, service or section, and full-time equivalent (FTE) employees. Table 8 provides the vacancy rates across the VISN as of February 1, 2021.

Table 8. Reported Vacancy Rates for VISN 8 Facilities (as of February 1, 2021)

Facility	Clinical Vacancies	Clinical Vacancy Rate (%)	Total Vacancy Rate (%)
VISN 8	1609.4	8.1	9.5
Bay Pines VA HCS (FL)	208.6	8.1	9.3
James A. Haley Veterans' Hospital (Tampa, FL)	196.9	6.4	8.4
Miami VA HCS (FL)	98.7	7.9	9.7
North Florida/South Georgia Veterans Health System (Gainesville, FL)	524.1	11.8	12.1
Orlando VA HCS (FL)	235.6	9.2	10.5
VA Caribbean HCS (San Juan, PR)	126.5	3.1	5.8
West Palm Beach VAMC (FL)	146.9	7.0	7.5

Source: VISN 8: VA Sunshine Healthcare Network Human Resources Officer (received March 22, 2021).

The OIG found the following primary care clinical vacancies across VISN 8:

- Physicians: ~71 FTE
- Physician assistants: ~1 FTE
- Nurse practitioners: ~14 FTE
- Nurses: ~135 FTE

[28] James Buchanan, "Reviewing the Benefits of Health Workforce Stability," *Human Resources for Health* 8, no. 29 (December 14, 2010), https://doi.org/10.1186/1478-4491-8-29.

Clinical staffing may be a contributing factor in wait time challenges at the Bay Pines VA HCS and North Florida/South Georgia Veterans Health System. The Bay Pines VA HCS had 14 physician FTE vacancies. The North Florida/South Georgia Veterans Health System had 19 physician, 1 physician assistant, 11 nurse practitioner, and 94 nurse FTE vacancies.

For mental health, the OIG found the following clinical vacancies across VISN 8:

- Psychiatrists: ~53 FTE
- Psychologists: ~84 FTE
- Nurses: ~58 FTE
- Social workers: ~105 FTE

The VISN's overall average wait time for new mental health patients was 11.0 days. The longest average facility wait time, 17.2 days, was at the North Florida/South Georgia Veterans Health System at 17.2 days. Given the potential opportunities to improve mental health wait times, clinical staffing may be a contributing factor at the North Florida/South Georgia Veterans Health System, where 17 psychiatrist, 27 psychologist, 25 nurse, and 44 social worker FTE positions were vacant.

The HRO reported holding meetings with the executive leadership team to review progress on hiring new staff for existing vacancies, review the "time to hire" report, and track timeliness of human resource actions.

As of February 1, 2021, the VISN employed 36,000 FTE employees. The HRO reported recruiting challenges in highly rural areas and salary competition with private sector and university affiliates in metropolitan areas. The VISN used resources for incentives like VA's Education Debt Reduction Program and recruitment and relocation bonuses.[29] In FY 2020, the VISN spent $1,105,422 on relocation bonuses; $3,036,772 on retention allowances; and $2,140,379 on recruitment bonuses for a total of $6,282,573. The VISN used 100 percent of its FY 2020 Education Debt Reduction Program allocations and had 467 active participants in the program.

At the time of the OIG virtual review, there were 335 FTE employees assigned to the CCC, which included 77 FTE nurses, 25 virtual care providers, 69 pharmacy staff, and 156 health administration staff.

[29] "Hiring Programs and Incentives," Department of Veterans Affairs, accessed January 5, 2022, https://www.vacareers.va.gov/Benefits/HiringProgramsInitiatives/. The "Education Debt Reduction Program (EDRP) authorizes VA to provide student loan reduction payments to employees with qualifying loans who are in positions providing direct patient care and that are considered hard to recruit or retain." Each VHA facility determines which positions will qualify for the Education Debt Reduction Program.

VISN recruitment efforts in FY 2020 included hosting virtual job fairs for several specialties, including a job fair/open house for physician residents completing their residencies. Also, HRO staff implemented a "hire right, hire fast" pilot to onboard medical support assistants across the VISN. This pilot resulted in an average time to hire of 44 days, and in FY 2021, the hiring of 409 medical support assistants. During the COVID-19 pandemic, the VISN used VA's rapid hiring processes to increase facility staffing levels and had onboarded 1,912 FTE staff since March 1, 2020.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders responded to identified problems. At the time of the review, VISN and facility leaders had closed all but eight recommendations for improvement listed in appendix D.[30]

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting developed the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[31] 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.[32]

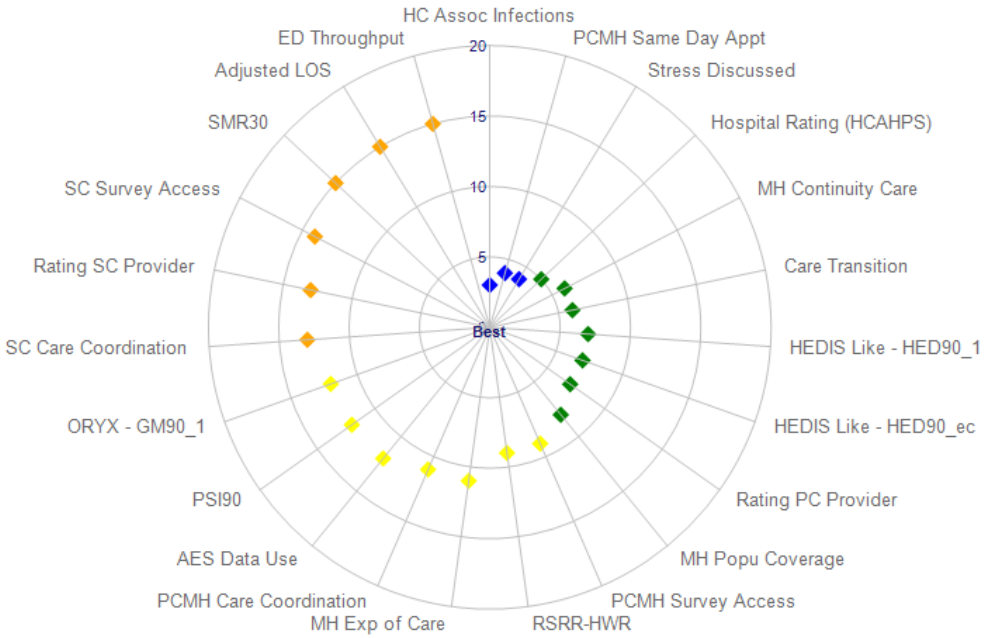
Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of September 30, 2020. The figure uses blue and green data points to indicate high performance (for example, in the areas of healthcare (HC) associated (assoc) infections, stress discussed, and care transition). Metrics that need improvement are in orange (for example, acute care 30-day standardized mortality ratio (SMR30), adjusted length of stay (LOS), and emergency department (ED) throughput).[33]

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

[31] "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 VA website not publicly accessible.)

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

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



Blue - 1st Quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th Quintile.

Figure 4. *VISN 8 quality of care and efficiency metric rankings (as of September 30, 2020).*
Source: VHA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.

VISN leaders pointed out that they did not have any performance measures in the lowest fifth quintile (red). VISN leaders reported being aware of fourth quintile items and explained efforts to improve ED throughput, LOS, and SMR30 scores. SAIL data were regularly monitored by leaders through the VISN's Integrated Care Dashboard, which included metrics segregated by facility, wait times, same day appointments, patient experience, Whole Health coaching, staffing ratios, and panel composition.

To address ED throughput, VISN leaders reported having many level 1A (highest complexity) facilities where veterans presented to the ED instead of making a regular appointment with their primary care provider, which can cause throughput problems and ED crowding. Leaders reported the following remedial actions:

- Contacting frequent ED users to offer and initiate case management
- Segregating space at the Orlando VA HCS for providers to virtually examine triaged non-emergent patients
- Detailing an ED nurse manager to fill a gap left by departed staff at the North Florida/South Georgia Veterans Health System

The VISN CMO stated that although the ED throughput metric was lower than that of other VISNs, Hospital Compare data from the Centers for Medicare & Medicaid Services showed

comparable wait times with community hospital EDs in the VISN 8 catchment areas; longer throughput times might be related to increased preadmission diagnostic testing performed at facility EDs.

VISN leaders reported that the adjusted length of stay had been affected by facility COVID-19 operations and that utilization management staff were reviewing data to determine the magnitude of the effect. VISN CLCs and community nursing homes were closed to new admissions, which increased the length of stay for patients awaiting discharge from the hospital.

For the 30-day standardized mortality ratio, VISN leaders identified preoperative screening and selection of high-morbidity patients for surgery as a contributing factor at one facility and conducted a VISN-level review to find ways to improve the performance measure.

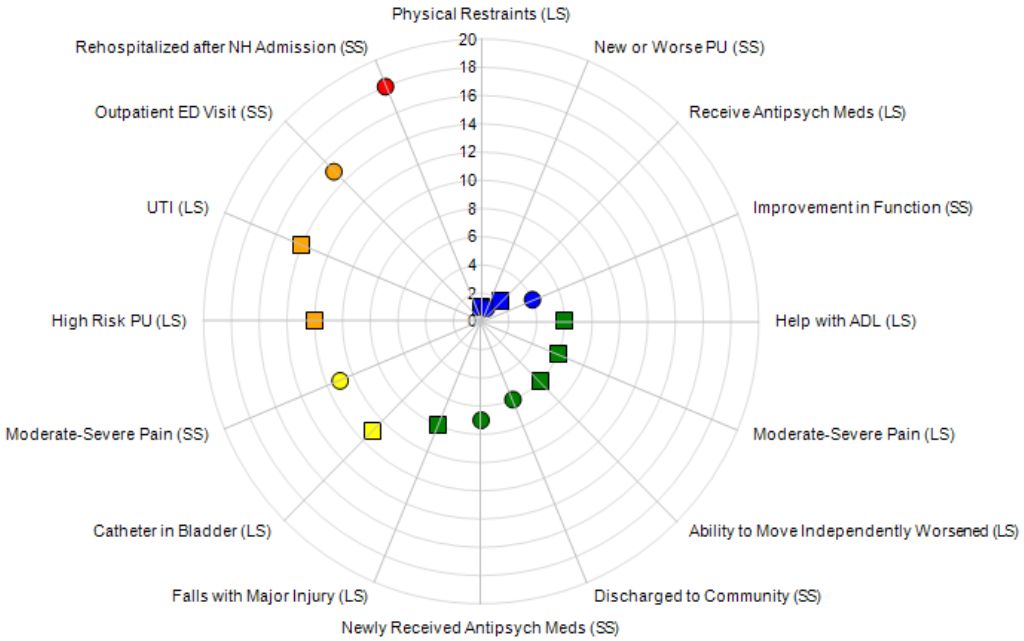
The SAIL Value Model also includes SAIL CLC, which is a tool to "summarize and compare performance of CLCs in the VA."[34] The SAIL model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[35]

Figure 5 illustrates the VISN's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and moderate-severe pain (LS)). Measures that need improvement are denoted in orange and red (for example, urinary tract infections (UTI) (LS), outpatient ED visit (SS), and rehospitalized after nursing home (NH) admission (SS)).[36]

[34] 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.

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

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



Blue - 1st Quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th Quintile.

Figure 5. *CLC quality measure rankings (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.

VISN leaders reported monitoring the low rehospitalized after NH admission (SS) score and stated that it was associated with rehospitalizations after discharge from a community nursing home as opposed to a CLC. Leaders also reported a need to improve medication management to lessen the need for patients to present to the ED for pain medications. Other VISN efforts to improve CLC care included staff

- organizing the CLCs into two divisions for education and clinical innovation activities,
- conducting mini-residencies on geriatric topics, and
- performing acupuncture to address pain management.

Observed Trends in Noncompliance

The OIG identified that the Network Director, CMO, and QMO/CNO had opportunities to improve their oversight of facility-level QSV, registered nurse credentialing, care coordination, and high-risk process functions.

During virtual CHIP visits of the VISN 8 facilities performed during the weeks of March 15 and March 22, 2021, the OIG noted noncompliance trends in the following areas:

- QSV
  - Surgical work group attendance
- Registered nurse credentialing
  - Primary source verification
- Care coordination (inter-facility transfers)
  - Transmission of active medication lists to receiving facilities
- High-risk processes (management of disruptive and violent behavior)
  - Committee meeting attendance
  - Staff training

In response to these trends, the Network Director stated that VISN staff would follow up with responsible facility directors, associate directors for patient care services, and associate directors.

Leadership and Organizational Risks Conclusion

The executive leaders had worked together since May 2019, when the Deputy Network Director for Operations was hired. The longest tenured member was the Chief Financial Officer, who was assigned in 2008. The Network Director was assigned in 2016. The CMO and HRO had been on board since 2017, the Deputy Director for CCC arrived in 2018, and the Deputy Network Director for Operations and QMO/CNO were appointed in 2019.

Selected survey scores related to employees' satisfaction with VISN leaders were generally higher than VHA averages. The Network Director had opportunities to improve servant leadership and employee attitudes toward the workplace. In the review of patient experience survey data, the OIG noted that VISN averages for the selected survey questions were similar to or higher than VHA averages. The VISN leaders appeared actively engaged with employees and patients and were working to sustain engagement and satisfaction.

The executive team leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics and should continue to take actions to sustain and improve performance measures.

The OIG's review of access metrics and clinical vacancies identified potential organizational risk factors at the Bay Pines VA HCS and North Florida/South Georgia Veterans Health System.

Further, the OIG identified that the Network Director, CMO, and QMO/CNO had opportunities to improve their oversight of facility-level QSV, registered nurse credentialing, care coordination, and high-risk process functions. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

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.[37] 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.[38]

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."[39] "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."[40]

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 VISN 8 and its leaders' subsequent response. 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 reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 8 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[41]

[37] "WHO Director General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed March 23, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

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

[39] 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). 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."

[40] 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.

[41] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 1 and 8*, Report No. 21-02969-20, November 18, 2021.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[42] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[43] Designated leaders are directly accountable for program integration and communication within their level of responsibility. Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[44]

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

- Designation of a systems redesign and improvement program manager[45]
- Establishment of a systems redesign and improvement advisory group that has representation from each VISN medical center[46]
- Assignment of a chief surgical consultant who also serves as chairperson of the VISN surgical work group[47]
- Designation of a VISN lead surgical nurse who participates in the VISN surgical work group[48]
    - Chairperson of conference calls with VA facility surgical quality nurses
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[49]
    - Monitoring of facility outlier data and communication of follow-up actions to VISN and facility directors

[42] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[43] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[44] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence.*
[45] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.
[46] VHA Directive 1026.01.
[47] VHA Directive 1102.01(1), *National Surgery Office*, April 24, 2019, amended on May 22, 2019.
[48] VHA Directive 1102.01(1).
[49] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.

  - Submission of quarterly VISN peer review data analysis reports to the Office of Quality, Safety, and Value
- Quarterly reporting of institutional disclosures to the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value[50]

Quality, Safety, and Value Findings and Recommendations

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

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

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[51] When certain actions are taken against a physician's license, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the physician meets licensure requirements for VA employment.[52] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO. The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with VHA policy," which includes VISN CMO oversight of facilities' processes.[53]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[54] When reports from the National Practitioner Data Bank or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

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

[51] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (The credentialing section of this handbook was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[52] VHA Handbook 1100.19, October 15, 2012.

[53] VHA Handbook 1100.19.

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

Medical Staff Credentialing Finding and Recommendation

The OIG identified weaknesses in the review and approval of physicians who had potentially disqualifying licensure actions prior to their VA appointment.

VHA policy states that physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review."[55] The physician's "credentials file must be reviewed with Regional Counsel, or designee, [and]...the review and the rationale for the conclusions must be forwarded to the VISN CMO for concurrence and approval of the appointment."[56]

The OIG reviewed profile information for 728 physicians, using publicly available data and VetPro, and did not find evidence that Regional Counsel, or a designee, reviewed the credentials files for 2 physicians who had a potentially disqualifying licensure action or that the VISN CMO approved the VA appointment.[57] One physician was hired in November 2020 with a medical license suspension from 1995 that was removed in July 1997. Another physician who was hired in September 2020, had a medical license placed on probation from 2014 until May 2015. Failure to conduct a documented review of licensure actions could lead to inappropriate hiring decisions that could subsequently affect the provision of quality care. The CMO reported not receiving notification from facility staff about the two cases and stated that facilities' credentialing staff attended training the previous year that did not include the CMO review portion of the credentialing process.

Recommendation 1

1. The Chief Medical Officer evaluates and determines any additional reasons for noncompliance and makes certain to review the credentials files and approve the VA appointments of physicians who had potentially disqualifying licensure actions.

[55] VHA Handbook 1100.19.

[56] VHA Handbook 1100.19.

[57] VHA Handbook 1100.19. "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file."

VISN concurred.

Target date for completion: March 31, 2022

VISN response: The Network Director has evaluated reasons for noncompliance and to ensure sustainment several actions have been taken. To improve the process for review of physicians who had potentially disqualifying licensure actions by the Chief Medical Officer (CMO) education was provided at the VISN 8 Healthcare Delivery Council and to the Credentialing and Privileging Staff in VISN 8. Additional actions taken include modification to the process for notification of the CMO when a review is required. This item requirement is reviewed during the annual Chief Medical Officer Credentialing and Privileging Program reviews which occurs at all VISN 8 facilities. Compliance will be monitored by the VISN 8 Credentialing and Privileging Program Officer. 6 months of data will be provided to demonstrate compliance.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that healthcare facilities provide a safe, clean, and functional environment of care for veterans, their families, visitors, and employees in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[58] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[59] VHA provides policy, mandatory procedures, and operational requirements for implementing an effective supply chain management program at VA healthcare facilities which includes responsibility for VISN-level oversight.[60]

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

- Establishment of a policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee that[61]
  - met at least quarterly;
  - documented an annual review within the previous 12 months of the VISN's
    - Emergency Operations Plan,
    - Continuity of Operations Plan, and
    - Hazards Vulnerability Analysis;
  - conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval; and

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

[59] VHA Directive 1608.

[60] VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018. (The directive was rescinded and replaced by VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.)

[61] VHA Directive 0320.01.

- assessed inventory management programs through an annual quality control review.[62]

Environment of Care Findings and Recommendations

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

[62] VHA Directive 1761(2).

Mental Health: Suicide Prevention

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.[63] 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.[64] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[65]

VHA requires VISN leaders to appoint mental health staff to serve as a member of its primary governing body, participate on each state's suicide prevention council or workgroup, and coordinate activities with state and local mental health systems and community providers.[66]

The OIG reviewed relevant documents and interviewed managers to determine whether VISN staff complied with various suicide prevention requirements:

- Designation of a mental health professional to serve on the VISN's primary governing body and each state's suicide prevention council or workgroup
- Designation of a mental health liaison to coordinate activities with state, county, and local mental health systems and community providers

Mental Health Findings and Recommendations

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

[63] "Suicide Prevention: Facts About Suicide," Centers for Disease Control and Prevention, accessed October 8, 2021, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

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

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

[66] Principal Deputy Under Secretary for Health Operations and Management (10N) Memorandum, *Patients at High-Risk for Suicide*, April 24, 2008. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

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.[67]

When VA or non-VA staff transfer a patient "to a VA facility in a manner that violates [VA] policy," the VISN CMO is responsible for contacting the transferring facility and conducting a fact-finding review to determine if the transfer was appropriate.[68] Examples of patient transfers that do not comply with VA policy include

- patients who were not appropriately screened and/or did not consent prior to transfer,
- patients who were not transferred with qualified personnel or equipment,
- transfers that were not approved by a VA physician, or
- pertinent medical records were not sent with patients at the time of transfer.[69]

The OIG reviewed relevant documents and interviewed key managers to determine whether the VISN CMO contacted the transferring facility and conducted a fact-finding review for reported cases of possible inappropriate transfers to a VA facility in calendar year 2020.

Care Coordination Findings and Recommendations

VISN staff stated that no incidents of inappropriate inter-facility transfers were reported to the CMO's office during calendar year 2020. The OIG made no recommendations.

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

Women's Health: Comprehensive Care

Women were estimated to represent approximately 10 percent of the veteran population as of September 30, 2019.[70] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans is anticipated to increase.[71] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[72]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive health care services in all VA medical facilities.[73] VHA also requires that VISNs appoint a lead women veterans program manager (WVPM) to serve as the VISN representative on women veterans' issues and identify gaps through "VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN."[74]

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

- Appointment of a lead WVPM
- Establishment of a multidisciplinary team that executes strategic planning activities for comprehensive women's health care
- Provision of quarterly program updates to executive leaders
- Monthly calls held with facility WVPMs and women's health medical directors
- Completion of annual site visits at each VISN facility
    - Needs assessment conducted
    - Progress towards implementation of recommended interventions tracked

[70] "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.
[71] "Veteran Population," National Center for Veterans Analysis and Statistics, accessed September 16, 2019. https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf.
[72] Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, Final Report, April 2015.
[73] VHA Directive 1330.01(4), *Health Care Services for Women Veterans,* February 15, 2017, amended January 8, 2021.
[74] VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018.

- Assessments to identify staff education gaps
  - Development of educational program and/or resources when needs identified
- Availability of VISN-level support staff for implementing performance improvement projects
- Analysis of women veterans' access and satisfaction data
  - Implementation of improvement actions when recommended

Women's Health Findings and Recommendations

The VISN complied with the appointment of a lead WVPM, establishment of a multidisciplinary team to execute strategic planning activities, monthly calls with facility women veterans program leaders, staff education gap assessments, access and satisfaction data analyses, and VISN-level support staff availability. However, the OIG identified a weakness with the completion of annual site visits at each VISN facility.

VHA requires lead WVPMs to complete "yearly site visits at each facility within the VISN and additional site visits as needed."[75] The OIG did not find compliance with annual facility site visits. The Lead WVPM visited the Tampa, Orlando, and Miami VA facilities in 2019 and the West Palm Beach facility in January 2020. The failure to conduct facility site visits could potentially hinder identification of program needs and development of action plans that support the provision of optimal women veterans care. The Lead WVPM stated there was a lack of training regarding required site visits and reported seeking assistance starting in 2019.

Recommendation 2

2. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that the Lead Women Veterans Program Manager completes yearly site visits at each facility within the Veterans Integrated Service Network.

[75] VHA Directive 1330.02.

VISN concurred.

Target date for completion: January 31, 2022

VISN response: The VISN 8 Women Veterans Program Manager has completed and scheduled the following require site visits for this calendar year for all VISN 8 Healthcare Systems:

Station 573, North Florida, South Georgia VA Healthcare System, Gainesville, FL: completed April 21, 2021.

Station 672, VA Caribbean Healthcare System, San Juan, PR.: completed July 13, 2021, and August 16, 2021.

Station 516, Bay Pines VA Healthcare System, Bay Pines, FL.: Completed August 12-13, 2021.

Station 673, James A. Haley VA Medical Center, Tampa, FL.: November 1-3, 2021.

Station 675, Orlando VA Healthcare System, Orlando, FL.: Scheduled for November 15, 2021.

Station 546, Miami VA Healthcare System, Miami, FL.: Scheduled for December 1, 2021.

Station 548, West Palm Beach VA Healthcare System, West Palm Beach, FL.: Scheduled for December 8, 2021.

The VISN 8 Network Director has evaluated reasons for noncompliance. To ensure sustainment, the VISN 8 Women Veterans' Program Manager will schedule in advance for the calendar year 2022 required site visits no later than January 31, 2022.

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 within this VISN, the OIG conducted a detailed review of key clinical and administrative processes associated with promoting quality care and provided two recommendations on issues that may adversely affect patients. While the OIG's recommendations are not a comprehensive assessment of the caliber of services delivered within this VISN, they illuminate areas of concern and guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines two OIG recommendations that are attributable to the Network Director and Chief Medical Officer. The intent is for VISN leaders to use these recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinical vacancies • Oversight inspections • VHA performance data • Observed trends in noncompliance	Two OIG recommendations that can lead to patient and staff safety issues or adverse events are attributable to the Network Director and Chief Medical Officer. See details below.
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 8 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Systems Redesign and Improvement Program staff and requirements • VISN Surgical Work Group • Collection, analysis, and action in response to VISN peer review data • Quarterly reporting of institutional disclosures for each facility	• None	• None
Medical Staff Credentialing	• Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements • Regional Counsel or designee's documented review to determine if the physician meets appointment requirements and subsequent concurrence/approval by VISN CMO	• The Chief Medical Officer reviews the credentials files and approves the VA appointments of physicians who had potentially disqualifying licensure actions.	• None
Environment of Care	• Establishment of a policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN Emergency Management Committee • Assessment of inventory management programs through an annual quality control review	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Suicide Prevention	• Designation of a mental health professional to serve on the VISN's primary governing body and each state's suicide prevention council or workgroup • Designation of a mental health liaison to coordinate activities with state, county, and local mental health systems and community providers	• None	• None
Care Coordination	• CMO contact and fact-finding review for reported cases of possible inappropriate inter-facility patient transfers	• None	• None
Women's Health: Comprehensive Care	• Lead women veterans program manager appointed • Multidisciplinary team that executes strategic planning activities established • Quarterly program updates provided to executive leaders • Monthly calls held with facility women veterans program managers and women's health medical directors • Annual site visits completed at each VISN facility • Staff education gap assessments conducted • Support staff available • Women veterans' access and satisfaction data analyzed	• None	• The Lead Women Veterans Program Manager conducts yearly site visits at each facility within the VISN.

Appendix B: VISN 8 Profile

The table below provides general background information for VISN 8.

Table B.1. Profile for VISN 8
(October 1, 2017, through September 30, 2020)

Profile Element	VISN Data FY 2018*	VISN Data FY 2019 †	VISN Data FY 2020‡
Total medical care budget	$5,686,080,384	$5,956,665,671	$7,103,013,544
Number of:			
• Unique patients	613,299	623,568	619,732
• Outpatient visits	8,781,120	8,917,287	8,498,707
• Unique employees§	24,382	25,188	26,726
Type and number of operating beds:			
• Community living center	869	869	869
• Domiciliary	375	437	437
• Hospital	1,602	1,607	1,621
Average daily census:			
• Community living center	585	587	516
• Domiciliary	306	299	210
• Hospital	1,095	1,079	912

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

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

**October 1, 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: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 8 (October 1, 2019, through September 30, 2020)

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	VHA	69.5
		VISN 8	75.0
		Bay Pines, FL	73.8
		Gainesville, FL	71.4
		Miami, FL	74.2
		Orlando, FL	82.2
		San Juan, PR	83.0
		Tampa, FL	71.8
		West Palm Beach, FL	72.7
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	82.5
		VISN 8	82.8
		Bay Pines, FL	82.5
		Gainesville, FL	81.8
		Miami, FL	83.5
		Orlando, FL	81.5
		San Juan, PR	81.9
		Tampa, FL	86.5
		West Palm Beach, FL	81.0
Survey of Healthcare Experiences of Patients (outpatient specialty care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.8
		VISN 8	84.3
		Bay Pines, FL	86.2
		Gainesville, FL	83.4
		Miami, FL	81.6
		Orlando, FL	84.9
		San Juan, PR	81.2
		Tampa, FL	86.8
		West Palm Beach, FL	86.1

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

Appendix D: Office of Inspector General Inspections

Table D.1. Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Clinical Assessment Program Review of the VA Caribbean Healthcare System, San Juan, Puerto Rico, Report No. 16-00551-128, March 8, 2017	October 2016	0	12	–	0
Clinical Assessment Program Review of the Orlando VA Medical Center, Orlando, Florida, Report No. 16-00565-154, April 13, 2017	November 2016	0	12	–	0
Healthcare Inspection – Alleged Unreported Surgical Incidents and Deaths, VA Caribbean Healthcare System, San Juan, Puerto Rico, Report No. 16-03150-277, June 27, 2017	–	0	0	–	–
Healthcare Inspection – Patient Safety and Quality of Care Concerns in the Community Living Center, James A. Haley Veterans' Hospital, Tampa, Florida, Report No. 17-01491-112, March 1, 2018	January 2017 February 2017 March 2017	0	6	–	0
Comprehensive Healthcare Inspection Program Review of the Miami VA Healthcare System, Miami, Florida, Report No. 17-01756-86, February 13, 2018	June 2017	0	11	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection Program Review of the Bay Pines VA Healthcare System, Florida, Report No. 17-01857-264, August 28, 2018	December 2017	0	4	–	0
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*	–	0	2	–	0
Delays in Processing Community-Based Patient Care at the Orlando VA Medical Center, Florida, Report No. 18-01766-78, February 20, 2019	March 2018	0	6	–	0
Comprehensive Healthcare Inspection Program Review of the West Palm Beach VA Medical Center, Florida, Report No. 18-01159-38, December 18, 2018	July 2018	0	8	–	0
Thoracic Surgery Quality of Care Issues and Facility Leaders' Response at the C. W. Bill Young VA Medical Center in Bay Pines, Florida, Report No. 18-01321-56, January 13, 2021	July/August 2018	0	5	–	5 †

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Alleged Poor Quality of Cancer Care at the VA Caribbean Healthcare System, San Juan, Puerto Rico, Report No. 18-01879-232, September 26, 2019	October 2018	1	6	0	0
Alleged Inadequate Response to a Missing Patient and Safety Concerns at the Bay Pines VA Healthcare System, Florida, Report No. 18-04132-163, July 18, 2019	January 2019	0	3	–	0
Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System, Gainesville, Florida, Report No. 19-00010-237, September 27, 2019	January 2019	0	28	–	3‡
Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital, Tampa, Florida, Report No. 19-00011-255, November 14, 2019	February 2019	0	7	–	0
Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center, Florida, Report No. 19-07429-195, August 22, 2019§	March 2019	1	9	0	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Ophthalmology Equipment and Related Concerns at the James A. Haley Veterans' Hospital, Tampa, Florida, Report No. 19-07095-253, November 7, 2019	March 2019	0	4	–	0

Source: Inspection/survey results verified with the Quality Management Specialist on March 22, 2021.

n/a = Not applicable.

[*] *In addition to the two recommendations for the Orlando VAMC (Florida), this report includes two recommendations for the Richard L. Roudebush VAMC (Indianapolis, Indiana) and four recommendations for the VA Illiana HCS (Danville, Illinois). However, for the purpose of this review, the OIG references only those recommendations under the scope of facilities within the VA Sunshine Healthcare Network.*

[†] *As of December 2021, 1 of 5 recommendations issued to the healthcare system remained open. This report also includes five recommendations under the purview of the VHA Under Secretary for Health. For the purpose of CHIP visits, the OIG references only those recommendations under the scope of the VISN and facilities.*

[‡] *As of December 2021, 1 of 28 recommendations issued to the healthcare system remained open.*

[§] *This report also includes one recommendation under the purview of the VHA Under Secretary for Health. For the purpose of CHIP visits, the OIG references only those recommendations under the scope of the VISN and facilities.*

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

Measure	Definition	Desired Direction
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
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Care transition	Care transition (inpatient)	A higher value is better than a lower 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	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
Hospital Rating	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
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

Measure	Definition	Desired Direction
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: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Discharged to community	Short-stay measure: percent of residents that did not have a CLC stay or hospital stay or death within 30-days post discharge to community.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Outpatient ED visit (SS)	Short-stay measure: percent of residents admitted to nursing home from hospital after and outpatient ED visit (an ED visit not resulting in hospital admission).
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.

Measure	Definition
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
Rehospitalization after NH admission	Short-stay measure: percent of residents with unplanned hospital 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: November 8, 2021

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

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 8: VA Sunshine Healthcare Network

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

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

I have reviewed the report, Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 8: VA Sunshine Healthcare Network. I concur with the findings and subsequent recommendations. I am submitting VISN 8's actions in response.

The VISN 8 point of contact regarding this report and/or the response is the VISN 8 Chief Quality Management Officer.

(Original signed by:)

Miguel H. LaPuz, M.D., MBA
Network Director, VISN 8

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