DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia

CHIP REPORT | REPORT # 21-00292-73 | JANUARY 31, 2022

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Figure 1. *Louis A. Johnson VA Medical Center in Clarksburg, West Virginia. Source: https://vaww.va.gov/directory/guide/* (*accessed July 29, 2021*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COS	Chief of Staff
COVID-19	coronavirus disease
FY	fiscal year
IDT	Interdisciplinary Team
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QSV	quality, safety, and value
RN	registered nurse
RRT	Rapid Response Team
SAIL	Strategic Analytics for Improvement and Learning
SOP	standard operating procedure
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Louis A. Johnson VA Medical Center and associated outpatient clinics in West Virginia. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

The OIG conducted an unannounced virtual review of the Louis A. Johnson VA Medical Center during the week of August 9, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings may

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

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

help this medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality. The OIG's Rapid Response Team simultaneously visited the medical center to conduct an onsite spot-check on specific areas that had recommendations for improvement in a report published three months earlier to determine if remediation efforts appeared to be on track (see appendix A).[3]

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued five recommendations to the Medical Center Director, Chief of Staff (COS), and Associate Director for Patient Care Services (ADPCS). These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, this medical center's executive team had no permanently assigned staff. Each executive leader position was covered using acting staff from the medical center, the Veterans Integrated Service Network, and other VHA facilities. The acting staff had worked together for approximately six weeks, except for the acting COS, who was assigned to cover the week of August 9, 2021. The acting Director, who had been detailed since January 2021, was the most tenured leader. Three of the prior permanent leaders were detailed to Veterans Integrated Service Network positions: the Director on December 23, 2020; the COS on February 2, 2021; and the ADPCS on February 28, 2021. Each of these positions remained encumbered (the Director and COS until May 2021, and the ADPCS until July 2021), so the positions could not be permanently filled until prior assigned staff were no longer eligible to return.[4] The Associate Director accepted another position and transferred on January 30, 2021.

Organizational communications and accountability were managed through a committee reporting structure, with Executive Leadership Board oversight of several working groups. Leaders monitored patient safety and care through the Quality Executive Council, which was responsible for tracking and trending quality of care and patient outcomes.

The OIG reviewed survey results and concluded the medical center's averages for the selected survey leadership questions were similar to or slightly lower than the VHA averages except for the servant leader index score, which was higher. However, none of the current acting leaders were in place at the time the fiscal year 2020 All Employee Survey was conducted. Patient

[3] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

[4] An encumbered position is one in which an employee has return rights to the position.

survey scores generally reflected higher care ratings for questions related to overall inpatient and outpatient care, but gender-specific scores revealed opportunities for improvement.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and identified opportunities for executive leaders to more consistently participate in the institutional disclosure process.[5]

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Investments in a culture of safety and quality improvements with robust communications and accountable leadership significantly contribute to positive patient outcomes in healthcare organizations. The OIG identified multiple executive leadership transitions since December 2020 as well as key vacancies within quality management and equal employment opportunity leadership roles. Vacancies in these critical areas represent leadership and organizational vulnerabilities. While current acting executive leaders articulated and demonstrated great strides with redesigning and improving patient care, promoting psychological safety for staff, and establishing thorough and methodical reviews for the selection process for leaders in these critical roles, continued oversight and support from VISN and VA Central Office leaders is imperative.

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."[6] 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.[7]

The acting executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or factors contributing to poor performance on specific SAIL measures. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during their acting roles to maintain or improve organizational performance, employee satisfaction, or patient experiences.

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[5] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leader(s) together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

[6] "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.)

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

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions and protected peer reviews.[8] However, the OIG identified deficiencies with a designated systems redesign and improvement coordinator and Surgical Work Group attendance.

Care Coordination

The OIG observed general compliance with requirements for the existence of a facility policy addressing inter-facility transfers, monitoring and evaluation of inter-facility transfers, and transmission of patients' active medication lists and advance directives to receiving facilities. However, the OIG identified deficiencies with the completion of required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent and communication between nurses at sending and receiving facilities.[9]

High-Risk Processes

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

Conclusion

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

[8] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements.

[9] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes H and I, pages 69–70, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 1 and 2 closed. 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 the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Louis A. Johnson VA Medical Center and the related community-based outpatient clinics examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.[1]

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

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

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

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

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

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

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

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

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

4. Registered nurse (RN) credentialing
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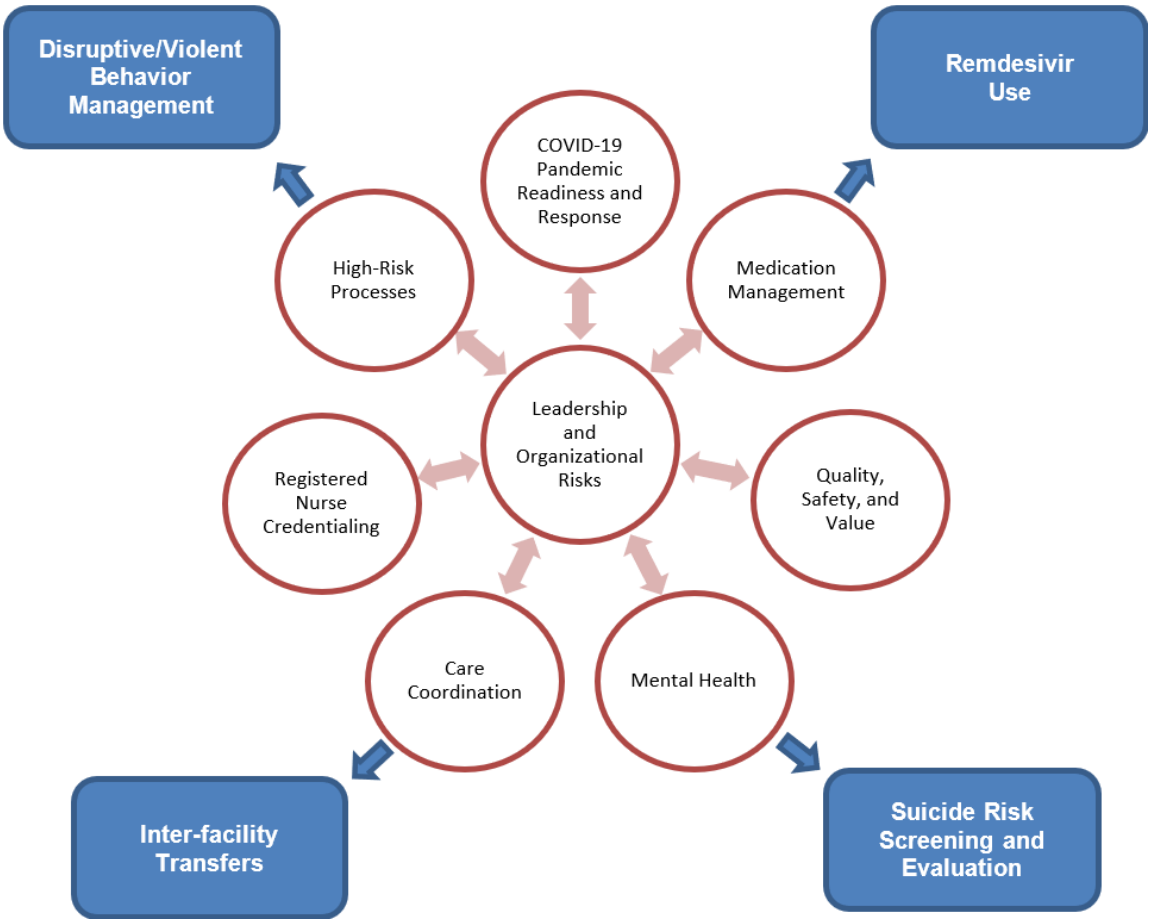

Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

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

Methodology

The Louis A. Johnson VA Medical Center also provides care through several outpatient clinics in West Virginia. Additional details about the types of care provided by the medical center can be found in appendixes C and D.

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

The inspection examined operations from May 7, 2018, through August 13, 2021, the last day of the unannounced multiday evaluation.[8] During the virtual review, the OIG did not receive any complaints beyond the scope of this inspection. The OIG's Rapid Response Team simultaneously visited the medical center to conduct an onsite spot-check on specific areas that had recommendations for improvement in a report published three months earlier to determine if remediation efforts appeared to be on track (see appendix A).

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

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

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

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the medical center response
8. VHA performance data (medical center)
9. VHA performance data (community living center (CLC))[11]

Executive Leadership Position Stability and Engagement

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

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

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

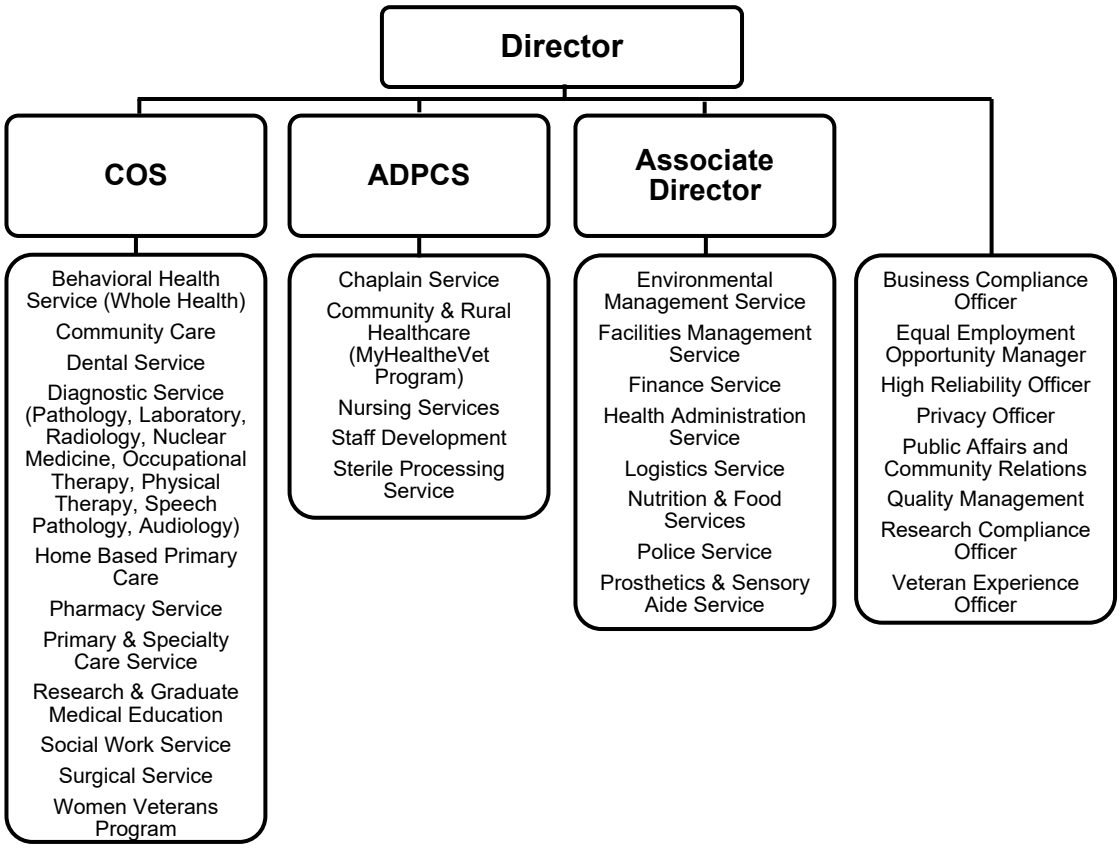

Figure 3. *Medical Center organizational chart.*

Source: Louis A. Johnson VA Medical Center (received August 9, 2021).

At the time of the OIG inspection, this executive team had no permanently assigned staff. Each executive leader position was covered using acting staff from the medical center, the VISN, and other VHA facilities. The acting staff had worked together for approximately six weeks, except for the acting COS. Three of the prior permanent leaders were detailed to VISN positions: the Director on December 23, 2020; the COS on February 2, 2021; and the ADPCS on February 28, 2021. Each of these positions remained encumbered (the Director and COS until May 2021, and the ADPCS until July 2021), so the positions could not be permanently filled until prior assigned staff were no longer eligible to return to their positions.[12] The Associate Director had accepted another position and transferred on January 30, 2021.

Table 1 reflects those staff who were assigned in acting roles at the time of the OIG virtual visit. Multiple staff had served in an acting capacity since the leadership positions became vacant, and each position had other staff cover when the acting executive was out of the office. The detail below is based on official memorandums provided by Human Resources. For any gaps in the

[12] An encumbered position is one in which an employee has return rights to the position.

dates noted below, staff were identified to cover the position but there were no official memorandums provided to the OIG.

- Before the acting Director (present at the time of the OIG review) began on January 4, 2021, a previous staff member had been assigned to cover the position on December 23, 2020.
- The acting COS, who started on August 9, 2021, also covered the position from February 22, 2021, until April 2021. Another physician covered the position from April 5 through August 2, 2021, and a third acted as COS from August 2 through August 8, 2021 (and was on notice to cover again starting August 23, 2021).
- Coverage for the ADPCS position started on December 29, 2020, two months before the previous ADPCS was assigned to the VISN. A second staff member was assigned the position from May to July 2021, and the most recent acting ADPCS had been in place since June 27, 2021.
- The associate director position was covered by three internal staff who had various dates of service between January and May 2021. The acting Associate Director in the position during the OIG's virtual review was the fourth leader in this role and had been in place since June 21, 2021.

The acting Director described the handoff process between acting executive leaders, explaining that periods of service often overlapped to ensure adequate transitions. The acting Director discussed the hiring status of permanent executive leaders in detail, noting that the selection process had been delayed because the positions were encumbered. The acting Director stated that leaders' multiple transitions had been difficult for medical center staff and emphasized that the selection process required adequate time to find executive leaders who would be the best fit for these positions. The acting Director also reported that tentative selections had been made for the director and COS positions, interviews were in progress for the associate director position, and the ADPCS position had been posted. Additionally, the medical center had a vacancy in the chief of quality management position, which had also been posted for recruitment.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	January 4, 2021 (acting)
Chief of Staff	August 9, 2021 (acting)
Associate Director for Patient Care Services	June 27, 2021 (acting)
Associate Director	June 21, 2021 (acting)

Source: Louis A. Johnson VA Medical Center Supervisory Human Resource Specialist, Strategic Business Unit (received August 10, 2021).

The acting Director served as the chairperson of the Executive Leadership Board, which has the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board oversaw the Medical, Quality, Administrative, and Patient Care Executive Councils. Leaders monitored patient safety and care through the Quality Executive Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Leadership Board. The interim Chief of Quality Management explained that, beginning in August 2021, the Quality Executive Council was to merge with the Executive Leadership Board to form one governance board (see figure 4).

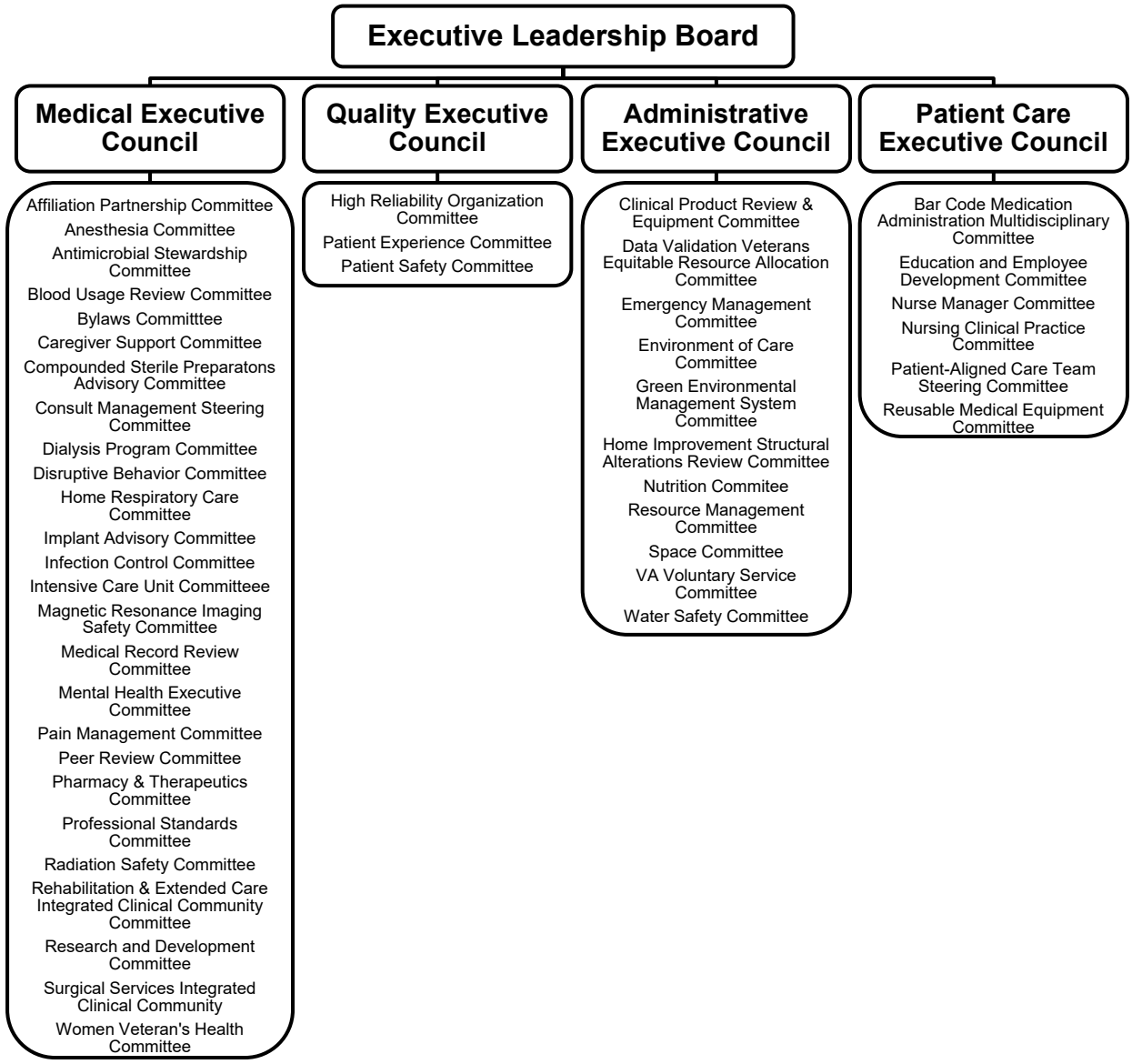

Figure 4. *Medical Center committee reporting structure.*

Source: Louis A. Johnson VA Medical Center (received August 9, 2021).

To help assess the medical center executive leaders' engagement, the OIG interviewed the acting Director, COS, ADPCS, and Associate Director regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the acting executive leaders were able to speak about actions taken during the time they served to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The medical center's FY 2020 annual medical care budget of $242,697,255 increased approximately18 percent compared to the FY 2019 budget of $205,912,839.[13] Because the acting Director was not in the role in FY 2020, the OIG reviewed the FY 2021 total operating budget, which was $263,585,954.[14] The acting Director and acting Associate Director reported that the increased funding for FY 2021 was used to purchase clinical equipment and increase pay based on market evaluations.

Additionally, the medical center received $31,560,686 in COVID-19 pandemic funding, for a total budget of $295,146,640 for FY 2021.[15] The acting Director stated that leaders are tracking the amount of money spent related to pandemic needs versus the normal operating budget. The acting Director also reported that the additional funding was used to offer overtime pay for staff working in weekend vaccination clinics and to hire

- medical support assistants,
- staff to provide COVID-19 screening,
- Environmental Management Services staff to meet additional cleaning requirements, and
- temporary Facilities Management Services staff to assist with creating negative pressure rooms.

The acting Director explained that funds were also used to purchase outdoor screening tents and personal protective equipment. The acting Director reported reviewing the number of medical center staff, determining that a reduction was warranted, and implementing a plan to realign and reduce overall budgeted staff throughout FY 2021 and 2022.

[13] VHA Support Service Center.

[14] The OIG obtained additional information from the Louis A. Johnson VA Medical Center Chief Financial Officer on August 19, 2021.

[15] The OIG obtained additional information from the Louis A. Johnson VA Medical Center Chief Financial Officer on August 19, 2021.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[16] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[17] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[18] Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[19]

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Medical Officer	1. Police
2. Medical Oncology	2. Medical Records Technician
3. Gastroenterology	3. –
4. Urology	4. –
5. Dermatology	5. –

Source: VA OIG.

At the time of the OIG inspection, acting executive leaders confirmed that the occupations listed in table 2 generally remained the top clinical occupational shortages. The acting COS confirmed urology and dermatology provider shortages and identified additional shortages for hospitalists, anesthesiologists, and surgeons. The acting Director described the use of telehealth and community care as current avenues to provide additional care: patients received oncology services via telehealth by a nurse practitioner through the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia or were referred to a community provider for care. Patients were also referred to the VA Pittsburgh Healthcare System for teledermatology services. The acting COS reported that specialty providers were difficult to recruit because of the rural location, competition from the local university and community hospitals whose salaries were higher, and lack of surgical robotics for urology procedures. The acting Associate Director reported current

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

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

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

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

challenges with recruitment of biomedical engineering, prosthetics, and Environment Management Services staff. The acting Associate Director attributed Environmental Management Services staffing shortages to delays with the centralized hiring process, frequent turnover, and the increased need for cleaning and disinfection during the pandemic.

The acting Associate Director reported that the shortage of police officers within the medical center had been resolved with changes in salaries and special recruitment pay. However, the acting Director and acting Associate Director identified a barrier due to the inability of newly hired police officers to work within their full scope because officer training centers were closed during the pandemic. The acting ADPCS identified additional nonclinical staffing shortages for human resources and equal employment opportunity specialists.

Several acting executive leaders described multiple delays and lack of response from the centralized human resources staff as additional barriers to hiring. They described ongoing efforts to address occupational shortages, which included reposting positions and offering incentives.

The OIG inspection team also determined through interviews that key vacancies existed within quality management, and that the equal employment opportunity manager position had been vacant since August 2020 (although the Washington DC VA Medical Center remotely supported the staff). In quality management, the acting Director reported that two Systems Redesign and Improvement Program positions had been vacated in early 2021, when the program's coordinator and specialist were promoted to positions at the VISN. The coordinator position had been reposted but not yet filled. Additionally, the chief of quality management position was vacated in May 2021 and had not yet been reposted. Applicants for the high reliability officer and patient safety manager positions had been selected, with staff transitions in process. The Strategic Analytics for Improvement and Learning (SAIL) coordinator position was also vacant but had not yet been posted.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[20] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on culture and organizational health.[21] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

[20] "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.)

[21] "AES Survey History."

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[22] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. The OIG found that the medical center averages for the selected survey leadership questions were slightly lower than VHA averages, except for the servant leader index score, which was higher.[23] Scores related to the Director, COS, and Associate Director were consistently higher than those for VHA and the medical center, while the scores for the ADPCS were consistently lower.[24]

[22] Ratings are based on responses by employees who report to the Director, COS, and Associate Director. However, for the FY 2020 AES results, ADPCS scores included both direct and general employee reports.

[23] 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.

[24] The 2020 All Employee Survey results are not reflective of employee satisfaction with the acting executive leaders, who were not in these roles when the survey was administered.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	COS Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*.*	0–100 where higher scores are more favorable	73.8	75.1	88.3	85.6	65.6	90.5
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.3	4.5	4.0	2.9	4.6
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.4	4.6	4.1	3.0	4.7
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.4	4.5	4.0	3.0	4.6

Source: VA All Employee Survey (accessed July 12, 2021).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[25] The medical center averages for the selected survey questions were similar to or better than the VHA averages. Scores related to the COS and Associate Director were consistently better than those for VHA and the medical center. However, opportunities appeared

[25] Ratings are based on responses by employees who report to the Director, COS, and Associate Director. However, for the FY 2020 AES results, the ADPCS scores included both general and direct reports.

to exist for the Director and ADPCS to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing), and the ADPCS to improve employee perceptions regarding disclosing a suspected violation of any law, rule, or regulation without fear of reprisal.

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	COS Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.8	4.3	3.4	4.9
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.5	4.3	3.8	4.3
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.3	2.0	1.1	1.7	0.4

Source: VA All Employee Survey (accessed July 12, 2021).

The acting Director described the current executive team as a group of strong and passionate leaders dedicated to working with staff during a difficult time of leadership transition. Acting executive leaders reported initially observing an environment where staff were guarded, resistant

to discussing concerns, and worked in silos. The leaders described changes taken to improve morale and psychological safety while creating a work environment that fosters open communication and transparency, including having open office hours and conducting frequent leadership rounds to visit staff in work areas during and after normal business hours. Each acting leader described the significance of implementing "We Care" rounds, which involve leaders from all service lines recognizing staff achievements and addressing barriers and concerns to promote communication, enhance morale, and build rapport. The acting Director discussed asking about issues that kept staff awake at night. Leaders reported that staff now appear more comfortable with openly discussing concerns.

Leaders also offered incentives such as "Great Catch" and "On-the-Spot" awards and recognized staff with thank-you notes and small tokens of appreciation. The acting ADPCS described the importance of staff engagement, which entailed including staff in decision-making processes as applicable, attending huddles, actively listening, empowering staff to offer solutions, and creating channels for staff to be heard. All the acting executive leaders attended New Employee Orientation and shared stories and experiences with new staff. The acting Director described the importance of recognizing outstanding work, as well as providing encouragement and assistance to staff when missteps occur.

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[26] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[27]

Acting executive leaders described zero tolerance for harassment and discrimination and reportedly implemented processes to ensure staff awareness of reporting options and when to escalate concerns. The acting Director discussed the "See Something, Say Something" campaign and the importance of promoting a psychologically safe culture within the medical center. Overall, acting leaders appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.

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

[26] "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.

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	COS Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.0	4.5	4.4	3.8	4.4
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.1	4.3	4.7	3.9	4.9
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.3	4.4	3.7	4.5

Source: VA All Employee Survey (accessed July 12, 2021).

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the medical center.[28] The overall patient satisfaction survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

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

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	70.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	86.0
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 "Very satisfied" and "Satisfied" responses.	84.8	87.1

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[29] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). In general, the patient satisfaction survey results reflected higher care ratings for males than the VHA averages. However, results revealed opportunities to improve their perceptions of inpatient doctors treating them with courtesy and respect. The score for female respondents' willingness to recommend the hospital were less favorable than VHA average for all female veterans nationally.

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

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	71.4	55.9
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	81.5	–‡
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	89.9	–‡

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

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

† *The medical center averages are based on 369–374 male and 9 or 10 female respondents, depending on the question.*

‡ *Data were not available due to the small number of respondents.*

For patient-centered medical home care, the results for female respondents were more favorable than the corresponding VHA averages. Scores for male respondents were generally higher than the VHA average, except for the provider rating.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	56.6	60.1
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	65.0	70.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	72.0	71.6

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

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

†*The healthcare system averages are based on 371–1,117 male and 31–60 female respondents, depending on the question.*

Specialty care survey scores for female respondents were higher than VHA averages. For males, scores were generally higher than VHA averages but indicated an opportunity for leaders to improve access to routine appointments.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	52.9	–‡
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	54.9	59.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	79.9	73.3

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

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

†*The healthcare system averages are based on 292–978 male and 8–35 female respondents, depending on the question.*

‡*Data were not available due to the small number of respondents.*

The acting Director reported receiving veteran feedback by performing bimonthly rounds, reviewing patient advocate reports, receiving letters, and reviewing handwritten comments in national Survey of Healthcare Experiences of Patients reports. The acting Director described receiving overwhelmingly positive feedback since arriving in January 2021, which had been shared with staff. In the few instances when negative feedback was received, leaders met with veterans and took steps for swift resolution. The acting COS stated that veterans were extremely loyal and supportive of the medical center. Several acting executive leaders communicated that female satisfaction scores are reflective of a dedicated women's health and mammography area. The acting COS explained that bus transport was provided to support access to specialty care at the VA Pittsburgh Healthcare System. The acting Associate Director described the medical center as being in a rural location and having strong ties to the community. The acting Associate Director also expressed how the current leadership team placed a strong emphasis on transparency and visibility through speaking with veterans and staff during rounds.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[30] Table 10 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[31] At the time of the OIG review, the medical center had closed all CHIP recommendations for improvement issued since the previous site visit conducted in May 2018, as well as all recommendations from a prior focused OIG report on alleged deficiencies in pharmacy procedures.[32]

Of particular note is the OIG's report, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson Medical Center in Clarksburg, West Virginia*, published on May 11, 2021.[33] The severity and reach of the report's findings regarding persistent failures prompted the OIG's Rapid Response Team to initiate follow-up during the time of the virtual CHIP visit. The intent was to assess leaders' progress in implementing corrective actions for deficient conditions identified in that report.[34] Appendix A addresses the results of this follow-up. The interim Chief of Quality Management reported working with managers and staff to address the open recommendations from this previous focused OIG report.

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

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

[32] VA OIG, *Alleged Deficiencies in Pharmacy Service Procedures at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 19-09776-223, August 4, 2020.

[33] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

[34] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*. Recommendations 2, 4, 6–12, and 14 were directed to the Louis A. Johnson VA Medical Center.

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[35] Additional results included the Long Term Care Institute's inspection of the system's CLCs.[36]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia*, Report No. 18-01136-313, October 24, 2018)	May 2018	9	0
OIG (*Alleged Deficiencies in Pharmacy Service Procedures at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 19-09776-223, August 4, 2020)	November 2019	3	0
OIG (*Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021)	July 2020	15	15*
TJC Unannounced Office of Quality and Patient Safety Review	October 2019	1	0
TJC Hospital Accreditation	May 2021	19	0
TJC Behavioral Health Care Accreditation		7	0
TJC Home Care Accreditation		4	0

Source: OIG and TJC (inspection/survey results received from the Accreditation Specialist on August 9, 2021).

**As of September 2021, 14 recommendations remained open.*

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

[36] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings."

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

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

Table 11 lists the reported patient safety events from May 7, 2018 (the prior OIG CHIP site visit), through August 8, 2021.[37]

Table 11. Summary of Selected Organizational Risk Factors (May 7, 2018, through August 8, 2021)

Factor	Number of Occurrences
Sentinel Events	9
Institutional Disclosures	13
Large-Scale Disclosures	0

Source: Louis A. Johnson VA Medical Center's acting Patient Safety Manager and Risk Manager (received August 9-10, 2021).

The acting Director reported being informed of serious adverse patient events through morning reports, weekly meetings with quality management staff, patient safety reports, emails, and phone calls to the Director's office. The acting Director spoke knowledgeably about the progress of actions to improve the quality and safety of care, including the implementation and closure of actions and monitoring of outcomes.

[37] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The Louis A. Johnson VA Medical Center is a mid-high complexity (1c) affiliated system as described in appendix C.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

Discussion with the acting Director revealed a collaborative decision-making process for determining when an institutional disclosure was warranted. For example, after a conversation among medical center leaders regarding the differences between institutional and clinical disclosures, the acting Director scheduled a meeting for the Risk Manager to provide a presentation to leaders to answer questions, provide education, and clarify the differences between the two types of disclosures. However, the OIG reviewed the institutional disclosures and identified opportunities for executive leaders to more consistently participate in the process.

Veterans Health Administration Performance Data for the Medical Center

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."[38] 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.[39]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities through December 31, 2020. Figure 5 shows the Louis A. Johnson VA Medical Center's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of influenza immunizations (FLU90_ec), adjusted length of stay (LOS), and hospital rating (HCAHPS)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, stress discussed, mental health (MH) continuity (of) care, care transition (HCAHPS), and Centers for Medicare & Medicaid Services (CMS) mortality (MORT)).[40]

[38] "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.)

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

[40] For information on the acronyms in the SAIL metrics, please see appendix F.

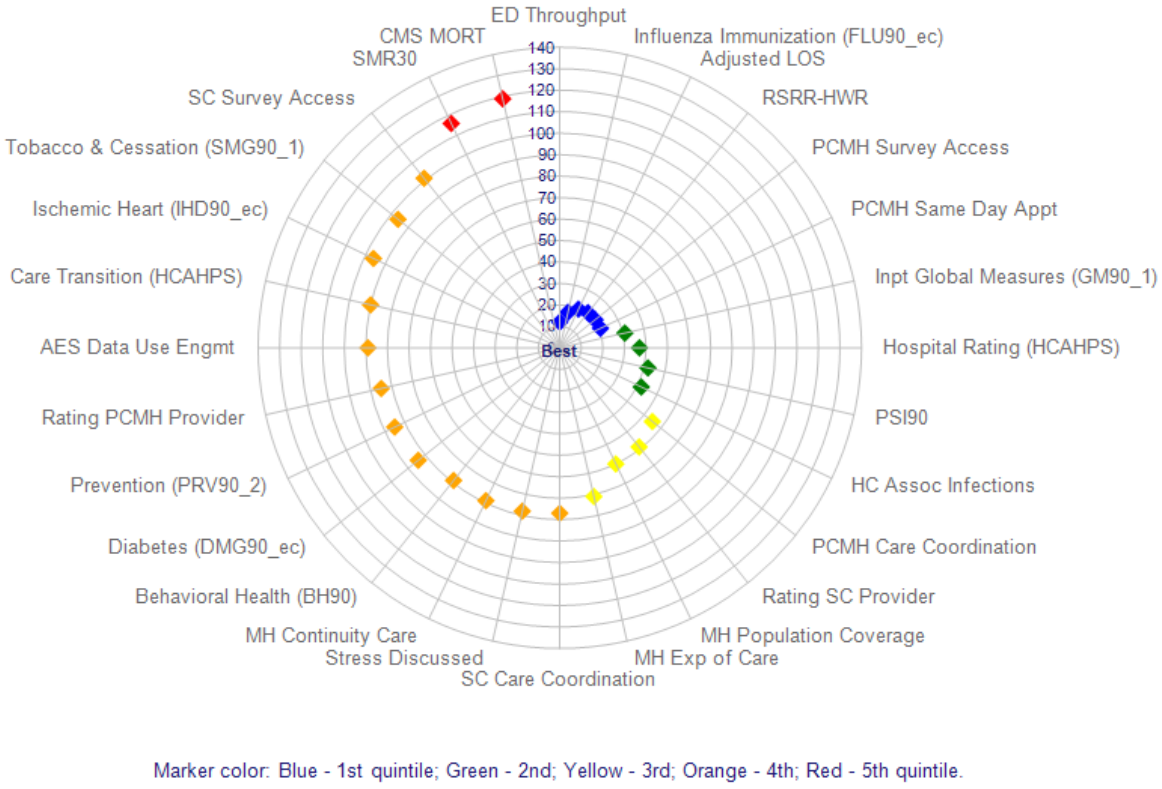

Figure 5. *System quality of care and efficiency metric rankings for FY 2021 quarter 1 (through December 31, 2020).*

Source: VHA Support Service Center.

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

The acting executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or factors contributing to poor performance on specific SAIL measures. In individual interviews, the acting executive leaders were able to speak about actions taken during the time they served to maintain or improve organizational performance. The acting Director described the implementation of interdisciplinary teams to conduct reviews of each SAIL metric, including mortality, which was also monitored through a redesigned Mortality Review Committee. The acting ADPCS discussed training two nurses to assist with mortality reviews.

Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[41] The model "leverages much of the same data" used in the Centers for

[41] 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.

Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[42]

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs through December 31, 2020. Figure 6 displays the Louis A. Johnson VA Medical Center's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of physical restraints–long-stay (LS), falls with major injury (LS), new or worse pressure ulcer (PU)–short-stay (SS), and moderate-severe pain (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, discharged to community (SS), moderate-severe pain (SS), rehospitalized after nursing home (NH) admission (SS), and high risk PU (LS)).[43]

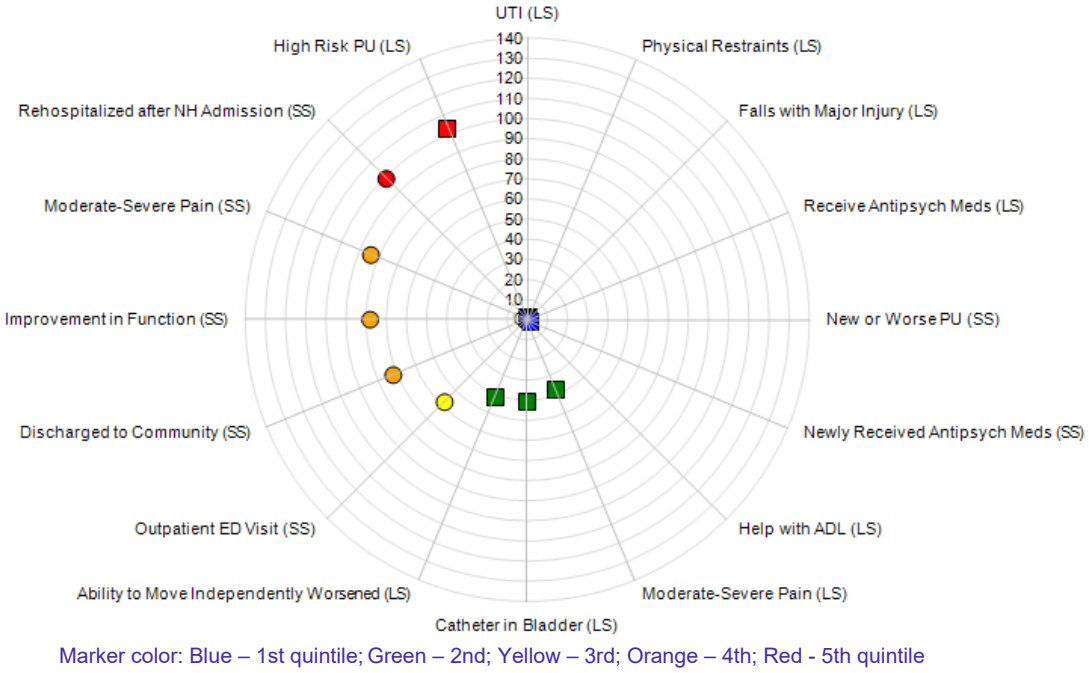

Figure 6. *Louis A. Johnson VA Medical Center CLC quality measure rankings for FY 2021 quarter 1 (through December 31, 2020).*

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.

[42] 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."

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

The acting executive leaders were also generally knowledgeable within their scope of responsibilities about factors contributing to poor performance on specific CLC SAIL measures. The acting ADPCS described implementing virtual assessments for wound care, which included collaborating with a subject matter expert from the Washington DC VA Medical Center, tracking and trending data, and convening a work group to review hospital readmissions.

Leadership and Organizational Risks Findings and Recommendations

At the time of the inspection, the acting Director served as the chairperson of the Executive Leadership Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The medical center's FY 2020 annual medical care budget of $242,697,255 increased approximately18 percent compared to the FY 2019 budget of $205,912,839. The executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Selected employee satisfaction survey responses demonstrated general satisfaction with leaders and maintenance of an environment where staff felt respected and discrimination was not tolerated, but responses also pointed to opportunities for leaders to reduce employees' feelings of moral distress at work. The OIG noted that the 2020 All Employee Survey results were not reflective of employee satisfaction with the acting executive leaders in place at the time of the virtual review because they were not in these roles when the survey was administered. Selected patient survey scores implied overall general satisfaction with care provided. However, selected gender-specific scores indicated opportunities for leaders to improve patient experiences in both inpatient and outpatient settings. The acting executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models.

However, the OIG identified multiple executive leadership transitions since December 2020, as well as key vacancies within quality management and equal employment opportunity leadership roles. Vacancies in these critical areas represent leadership and organizational vulnerabilities. Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Investments in a culture of safety and quality improvements with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations. While current acting executive leaders articulated and demonstrated great strides with redesigning and improving patient care, promoting psychological safety for staff, and establishing thorough and methodical reviews for the selection process for leaders in these critical roles, continued oversight and support from VISN and VA Central Office leaders is imperative.

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.[44] 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.[45]

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."[46] "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."[47]

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

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

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

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

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

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

[46] 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."

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[48] 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.[49] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[50]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center's committee responsible for QSV oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

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

The OIG reviewers also assessed the medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[51] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[52] The OIG team examined various requirements related to systems redesign and improvement:

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

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

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[53] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[54] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[55] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[56]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[57]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[58] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities;

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

[54] VHA Directive 1190.

[55] VHA Directive 1190.

[56] VHA Directive 1190.

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

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[59] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (RN)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[60]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[61]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions and protected peer reviews. However, the OIG identified deficiencies with a designated systems redesign and improvement coordinator and the Surgical Work Group.

VHA requires facilities to have a designated systems redesign and improvement coordinator to "[s]erve as an improvement SME [subject matter expert], supporting improvement projects aligning with VHA, VISN, and facility strategic goals."[62] The OIG found that the systems redesign and improvement coordinator position had been vacant since February 2021. This may result in inadequate program oversight and potential missed opportunities for continuous system improvement. The interim Chief of Quality Management stated that between February and June 2021, the medical center's Systems Redesign and Improvement Coordinator and one Systems Redesign and Improvement Specialist were selected and promoted to VISN positions. The Risk Manager reported that multiple vacancies within the Quality Management Service made it difficult to designate staff as an acting systems redesign and improvement coordinator.

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

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

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

[62] VHA Directive 1026.01.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and designates a systems redesign and improvement coordinator.[63]

Medical center concurred.

Target date for completion: Completed

Medical Center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. The facility posted for a system redesign and improvement coordinator on September 11, 2021 and selected a candidate for this position. The candidate began in the position on November 8, 2021. We have completed actions to resolve this recommendation. We request OIG consider closure of this recommendation based on evidence provided.

VHA requires that the facility's Surgical Work Group meets monthly and has a membership that includes, but is not limited to, the COS, Surgical Quality Nurse, and Operating Room Nurse Manager.[64] Medical center staff reported that 12 meetings were held from August 1, 2020, through July 31, 2021, but did not provide evidence of attendance for the August 2020 meeting. Additionally, the prior permanent COS attended only 1 meeting between September 2020 and January 2021, but an acting COS attended all meetings held from February through July 2021.[65] Inconsistent attendance by the COS could result in the absence of authority and expertise required to identify challenges, create a plan, and implement actions to optimize surgical program outcomes. The Associate Chief Nurse of Acute Care stated the prior permanent COS had not been available to attend Surgical Work Group meetings even though staff had made efforts to reschedule meetings to accommodate the COS's schedule.[66]

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures the Chief of Staff regularly attends Surgical Work Group meetings.[67]

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

[64] VHA Directive 1102.01(1).

[65] There were two acting Chiefs of Staff that served in the position from February through July 2021.

[66] The Surgical Work Group reports to the Medical Executive Committee.

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

Medical center concurred.

Target date for completion: Completed

Medical Center response: The Medical Center Director evaluated and determined there were no additional reasons for noncompliance. The Acting Chief of Staff attended Surgical Work Group monthly from February 2021 to June 2021 as noted in the report. In addition, the Acting Chief of Staff or Chief of Staff has continued to attend monthly Surgical Work Group meetings consistently making this action compliant for longer than six consecutive months. We have completed actions to resolve this recommendation. We request OIG consider closure of this recommendation based on evidence provided.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[68] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[69]

VA requires all RNs to hold at least one active, unencumbered license.[70] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[71] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[72] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[73]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 18 RNs hired from July 1, 2020, through July 11, 2021. The OIG determined whether

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

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

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[68] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (VHA Directive 2012-030 was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. The two documents contain similar language regarding credentialing procedures.)

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

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

[71] 38 U.S.C. § 7402.

[72] VHA Directive 2012-030.

[73] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

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

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

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

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[78] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

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

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

- the electronic health records of 50 randomly selected patients who were seen in the emergency department from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[79]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients."[80] Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[81]

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

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

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 40 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with requirements for the existence of a facility policy addressing inter-facility transfers, monitoring and evaluation of inter-facility transfers, and transmission of patients' active medication lists and advance directives to receiving facilities. However, the OIG identified deficiencies with the completion of required elements of the VA

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

[80] VHA Directive 1094.

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

Inter-Facility Transfer Form or facility-defined equivalent, and communication between nurses at sending and receiving facilities.

VHA requires the medical center's COS and ADPCS to ensure referring physicians complete all required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent prior to transfer, which include the patients' informed consent, stability and reason for transfer, and identification of the receiving physician.[82] For the electronic health records reviewed, the OIG estimated that referring physicians did not record the following information on the transfer forms:

- Patient or legally responsible person's informed consent (27 percent)[83]
- Medical and/or behavioral stability (57 percent)[84]
- Reason for transfer (45 percent)[85]
- Receiving physician (22 percent)[86]

These deficiencies could result in the unsafe transfer of patients, the inability to accurately monitor and evaluate transfer data, and an incomplete medical record. The Transfer Coordinator reported a lack of understanding of the directive and stated that the process had been for the Transfer Coordinator or Nursing Supervisor to complete the inter-facility transfer form without physician oversight.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that the referring physician completes all required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent prior to patient transfer.

[82] VHA Directive 1094.

[83] The OIG estimated that 95 percent of the time, the true compliance rate is between 58.13 and 85.36 percent, which is statistically significantly below the 90 percent benchmark.

[84] The OIG estimated that 95 percent of the time, the true compliance rate is between 27.50 and 57.90 percent, which is statistically significantly below the 90 percent benchmark.

[85] The OIG estimated that 95 percent of the time, the true compliance rate is between 39.03 and 70.00 percent, which is statistically significantly below the 90 percent benchmark.

[86] The OIG estimated that 95 percent of the time, the true compliance rate is between 63.88 and 89.74 percent, which is statistically significantly below the 90 percent benchmark.

Medical Center concurred.

Target date for completion: March 31, 2022

Medical Center response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Transfer Coordinator provided education to referring providers regarding all the VA Inter-Facility documentation requirements. Audits were conducted by the External Review Coordinator, Transfer Coordinator or Quality Specialist on all outgoing transfers each month and the 90% goal has been met for six consecutive months. Compliance for the completion of VA Inter-Facility documentation requirements will be reported to the Executive Leadership Board by the Transfer Coordinator. Once reported to the Executive Leadership Board for two consecutive quarters, we will request closure to this action.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at both the sending and receiving facility.[87] The OIG did not find evidence of nurse-to-nurse communication for 13 of 40 inter-facility transfers (32 percent).[88] This could result in staff at the receiving facility lacking the information needed to care for patients. The Emergency Department Nurse Manager reported believing that nurses conducted the handoff but did not document the communication. In January 2021, after discussions with peers across VHA (prompted by OIG findings at other facilities), they became aware of the requirement and implemented improvement actions.

Recommendation 4

4. The Associate Director of Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures nurse-to-nurse communication occurs between sending and receiving facilities.

[87] VHA Directive 1094.

[88] The OIG estimated that 95 percent of the time, the true compliance rate is between 52.63 and 81.58 percent, which is statistically significantly below the 90 percent benchmark.

Medical center concurred.

Target date for completion: March 31, 2022

Medical Center response: The Acting Associate Director of Patient Care Services evaluated and determined no additional reasons for noncompliance. The Transfer Coordinator provided education to all applicable RN's regarding nurse-to-nurse communication documentation requirements for the inter-facility transfer process. Audits were conducted by the External Review Coordinator, Transfer Coordinator or Quality Specialist on all outgoing transfers each month and the 90% goal has been met for six consecutive months. Compliance for the completion of VA Inter-Facility documentation requirements will be reported to the Executive Leadership Board by the Transfer Coordinator. Once reported to the Executive Leadership Board for two consecutive quarters, we will request closure to this action.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[89] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[90] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[91]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[92]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[93]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[94]

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

[90] VHA Directive 2012-026.

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

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

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

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[95] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[96] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG determined that the medical center addressed many of the requirements for the management of disruptive and violent behavior. However, the OIG identified a deficiency with completion of required staff training.

VHA requires that staff complete prevention and management of disruptive behavior training based on the risk level assigned to their work area.[97] The OIG found that 12 of 30 employees (40 percent) had not completed required training. This could result in lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Coordinator reported that face-to-face training requiring close contact was on hold due to the pandemic and inability to maintain social distancing. Additionally, the coordinator reported a backlog because of limited instructors and class sizes.

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

[96] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

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

Recommendation 5

5. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[98]

Medical Center concurred.

Target date for completion: October 31, 2022

Medical Center response: The Prevention and Management of Disruptive Behavior (PMDB) Coordinator is implementing a new tracking spreadsheet and reporting process for monitoring overall employee compliance with completion of Level 2 low, Level 2 moderate/high and Level 3 PMDB training reflective of the annual Workplace Behavioral Risk Assessment (WBRA). With the implementation of PMDB Level 2 virtually in January 2022, the new process will also track and report on required PMDB Level 2 low completion rates. PMDB Level 2 moderate/high and Level 3 remains suspended per facility leadership direction during the COVID-19 pandemic response due to a rise in COVID rates in our region. Once the facility determines it is safe to lift restrictions, the tracking and reporting process will also include PMDB Level 3 compliance. This data will be reported monthly by the PMDB Coordinator to the Executive Leadership Board. Compliance will be monitored for 90 percent or greater compliance per required service for six consecutive months.

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

Report Conclusion

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

Appendix A: Summary of OIG's Rapid Response Team Review Findings

In a separate, but coordinated effort with the CHIP team, the OIG deployed a Rapid Response Team (RRT) to the facility August 9–13, 2021, to follow up on specific concerns related to the OIG's recommendations issued in a previous report, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia* (Care and Oversight Deficiencies), that was published in May 2021.[99] In that report, the OIG concluded that the facility had serious, pervasive, and deep-rooted clinical and administrative failures that contributed to a nursing assistant's criminal actions not being identified and stopped earlier. Specifically, the nursing assistant pled guilty to deliberately administering insulin to eight patients in 2017 and 2018, resulting in severe hypoglycemia and death. The failures occurred in virtually all of the critical functions and areas required to promote patient safety and prevent avoidable adverse events at the facility. The OIG made 15 recommendations that addressed background investigation documentation, rescue medication security and management, and mortality data analyses; management and other clinical reviews; and inventory accountability, endocrinology consults, clinical communication expectations and forums, clinical documentation reviews, clinical care-related reporting expectations, patient safety event training, interdisciplinary mortality work group activities, governance structure oversight and reporting, and a culture of safety.

The purpose of the August 2021 OIG RRT inspection was to assess the remediation status of selected deficient conditions that directly impacted patient care and safety. While all 15 of the report's recommendations will be tracked quarterly until they are closed, in accordance with OIG follow-up practices, the OIG RRT focused on spot-checking the following areas of concern (see table A1).

[99] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

Table A.1. Follow-Up from the May 2021 *Care and Oversight Deficiencies* Report

OIG Areas of Concern	Associated Recommendation Number
Clinical Communications and Forums	6
Patient Safety and Incident Reporting	9, 10, 14
Interdisciplinary Mortality Review	11
Medication-Related Security and Tracking Processes	2
Personnel-Related Issues and Background Investigation Adjudication	None
Hospice and Palliative Care Program	None

Source: VA OIG RRT.

The OIG RRT inspected ward 3A (the medical/surgical unit), the intensive care unit, and the locked behavioral health unit; interviewed facility and VISN employees, managers, and leaders; reviewed facility policies, meeting minutes, and quality management documents; and evaluated personnel actions and other human resource-related activities.

Highlights of RRT Findings

Because only three months had elapsed from the date of the May 2021 *Care and Oversight Deficiencies* report publication to the OIG's site visit, not enough time had elapsed to evaluate the corrective actions beyond determining whether efforts seemed to be heading in the right direction or appeared stalled.

This report does not exhaustively address all the areas reviewed by the OIG RRT as shown in table A.1; rather, it describes the general status of specified conditions and recommendations and provides examples of corrective actions as of the August 2021 site visit.

Clinical Communications and Forums

The May 2021 *Care and Oversight Deficiencies* report referenced a variety of clinical communication deficits, which may have contributed to providers not recognizing the emerging pattern of hypoglycemic events and deaths sooner. These included the inadequate use of inpatient interdisciplinary team (IDT) rounds and a lack of routine staff meetings and conferences in which to discuss patient outcomes. TJC requires that hospital staff coordinate a patient's care, treatment, and services based on the patient's needs.[100]

In response to the OIG's recommendations, on May 11, 2021, the facility published a policy guiding the IDT and discharge planning processes, which includes IDT membership,

[100] The Joint Commission, *E-dition,* PC.01.03.01, January 1, 2021, "The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing."

communication expectations, and roles of the members in discharge planning.[101] In addition, the facility's draft hospitalist memorandum, dated June 10, 2021, defines the hospitalists' schedules, communication obligations, consultation services, documentation requirements, and other hospitalist duties.[102] The draft hospitalist memorandum requires the physician of record (the hospitalist) to complete the physician component of the IDT note in the electronic health records.[103] The facility also developed a draft service agreement with specialty services and an Emergency Department Hospitalist Admission Procedure that included hospitalist responsibilities.[104]

In August 2021, the acting Chief Hospitalist told the OIG that scheduling and attendance at staff meetings was a challenge, explaining that attempts at scheduling monthly in-person and virtual meetings to improve communications had mixed results. During this interview, the acting Chief Hospitalist also said, "We [have] tried meetings on [a virtual communication platform] in the past. One of the problems is if you are off tour…you are not going to be there. We [have] tried face-to-face and make it mandatory. You still miss people."

A chain of command standard operating procedure (SOP) was also created to "provide nursing services staff with appropriate direction for the prompt handling of patient care issues."[105] This policy was delivered via email to nursing staff in January 2021, with the request to utilize the voting button to demonstrate they read and understood the policy.[106]

While the OIG found that the facility was taking action to improve communications and provide forums, additional time was needed for these efforts to prove sustainable. The OIG will follow up to evaluate the effectiveness of these actions.

[101] Facility Policy 122-16, *Interdisciplinary Treatment and Discharge Planning*, May 11, 2021. The policy outlines the process for patients to receive health care and discharge guided by an individualized, interdisciplinary, interactive treatment and discharge planning process documented in VHA's automated Computerized Patient Record System.

[102] Facility Draft Memorandum, *Support Agreement between Directorate of Medicine and Hospitalist providers,* June 10, 2021.

[103] Facility Draft Memorandum, June 10, 2021.

[104] Draft *Emergency Department Hospitalist Admission Procedure,* February 15, 2021. This draft establishes the roles and responsibilities of the emergency department provider and the admitting hospitalist for an emergency department inpatient admission. Draft *Temporary Inter-service Agreement of Subspecialties Service under Surgery and the Inpatient Hospitalist section, under Medical Service*, June 7, 2021. This draft serves as an inter-service agreement between the Inpatient Hospitalist Section under the Medicine Service and the Subspecialties Section under the Surgery service and specifies the co-management of eligible veterans who receive inpatient care at Louis A. Johnson VA Medical Center. Facility Draft Memorandum, June 10, 2021.

[105] Facility Patient Care Services Standard Operating Procedure 118-204, *Chain of Command*, January 20, 2021.

[106] The OIG did not determine the number of staff who responded to the email as it was not the focus of this review.

Safety and Incident Reporting

The *Care and Oversight Deficiencies* report noted that some facility staff members did not complete patient safety reports related to the events in 2018. The report also noted that staff lacked knowledge about the types of patient safety events to be reported and how to report them, and that the former Patient Safety Manager did not adequately educate facility staff on the reporting processes. The facility's planned actions in response to the recommendations included educational opportunities for all staff to understand the Joint Patient Safety Reporting system and the appropriate reporting of actual or potential patient safety events, as well as promoting a facility-wide culture of safety.[107]

In August 2021, the OIG interviewed frontline staff who were able to articulate the types of safety events that can be reported and the process for reporting them. Supporting documentation reflected a 57 percent increase in patient safety events entered into the Joint Patient Safety Reporting system from March through July 2021. Further, the OIG found evidence of monthly patient safety rounding. The OIG noted that staff members who were interviewed could verbalize the meaning of and process for "see something, say something."[108]

VHA's High Reliability Organization initiative is an integral component of patient safety efforts to decrease patient harm in highly complex, high-risk environments. Staff members, who were interviewed, told the OIG that High Reliability Organization staff trainings were ongoing, and that staff felt safe to report incidents or issues to their supervisor or manager. The facility reported that more than 90 percent of High Reliability Organization training was completed for all staff.[109]

The OIG found that the facility's actions to promote a culture of patient safety such as safety standdowns, staff education and training, and patient care communication boards were important first steps, but that continued efforts and vigilance were needed to promote and sustain a culture of safety.

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[107] "Frequently Asked Questions: National Center for Patient Safety," VHA National Center for Patient Safety, accessed December 21, 2021, https://www.patientsafety.va.gov/about/faqs.asp#:~:text=A%3A%20In%202018%2C%20the%20Veterans%20Health%20Administration%20began,misses%20for%20the%20Military%20and%20Veterans%20Health%20Systems. Joint Patient Safety Reporting (JPSR) "standardizes event capture and data management of medical errors and close calls/near misses for the Military and Veterans Health Systems."

[108] VA OIG, *Combined Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, Iowa*, Report No. 13-03621-57, February 3, 2014. "See Something Say Something" is a process that allows staff to report most concerns.

[109] *VHA High Reliability Organization (HRO) Reference Guide*, March 2021. HROs are organizations that have been shown to experience fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments. In February 2019, VHA rolled out a new initiative outlining steps toward becoming an HRO, which includes various training experiences. The path to achieving *Zero Harm* in a high-risk environment relies on the strength and interconnectedness of QSV and patient safety processes, HRO integration, and reporting and oversight.

Interdisciplinary Mortality Review

The *Care and Oversight Deficiencies* report reflected that during the nursing assistant's tenure, the number of actual in-hospital deaths exceeded the expected deaths multiple times. While a mortality spike does not automatically imply quality of care deficits or suggest prohibited or unlawful activities, it does reflect a change from the facility's normal pattern and may merit further examination of conditions common to each of the deaths. The OIG found the facility did not maintain a process to conduct rigorous review of mortality data to identify outliers or track and trend results.

On June 4, 2021, the facility's Mortality Workgroup discussed the new SOP for death reviews represented in an algorithm. The acting Medical Center Director signed the SOP on June 25.[110] As noted in the SOP, "This policy will enable implementation by providing organizational framework for the process and management of mortality reviews and reporting, ensure that clear reporting mechanisms are in place to escalate concerns timely, and ensure that mortality monitoring data is analyzed and acted upon as appropriate." Tracking and trending deaths through one standardized SOP using approved screening tools within the SOP can ensure that deaths have gone through equitable analyses.

The OIG reviewed the Mortality Workgroup meeting minutes for June–August 2021, which reflected adherence to the facility's new SOP for death reviews. The facility reviews deaths individually by processing them via the Occurrence Screen 109 Death Review, VSSC G-Chart Review, or the 30-day Mortality Report Review through the appropriate service for clinical review in addition to review by Quality Management staff. The Risk Manager is responsible for tracking those reviews.[111] The Mortality Workgroup members determine the appropriate disposition of the cases, such as referral to Peer Review Committee, medical service's Morbidity and Mortality Committee, Ethics Committee, or request for management review.[112] The COS and Risk Manager discuss the workgroup death dispositions prior to the referral.[113]

Although not required, the OIG found that the mortality review process, as outlined in the SOP, could be enhanced if the workgroup obtained the final analysis of a death case after the disposition. With this additional step, the information could be tracked and trended if needed

[110] Facility SOP, *Mortality Review,* June 24, 2021.

[111] VA Office of Enterprise Development, Management & Financial Systems, *Occurrence Screen V. 3.0 User Manual, September 1993, revised, June 2016.* The occurrence screens are automated tools used by the Risk Manager to gather, track data, produce reports and create spreadsheets. Facility SOP, *Mortality Review*.

[112] On a monthly basis, the Mortality Workgroup reports to the Mortality Committee, which reports to the Quality Executive Council.

[113] Facility SOP, *Mortality Review*.

among the workgroup members and then presented to the Mortality Committee.[114] The Mortality Committee has responsibility for analyzing the aggregated death data and providing action plans, but this additional data could provide context to demonstrate how individual deaths fit into the aggregated mortality.[115] While the OIG determined that the facility was making progress on improving the mortality review process, additional time is needed to establish the effectiveness of that process.

Medication-Related Security and Tracking Processes

The *Care and Oversight Deficiencies* report reflected that medication security was inadequate on ward 3A, where the nursing assistant primarily worked in 2018. The OIG informed the facility of gaps in medication security during the initial inspection in 2018, and in 2021, the OIG confirmed that the medication carts and medication room have been secured through personal identity verification and security code access measures. In addition, security surveillance cameras were installed in hallways outside of medication rooms.

According to VA policy, "camera monitors must be located in an area continuously monitored by VA police to ensure an immediate and appropriate response."[116] In August 2021, the OIG conducted a physical inspection of the facility's ward 3A, the intensive care unit, the locked behavioral health unit, and the police operations area. In the police operations area, the OIG observed monitors from security surveillance cameras installed throughout the facility. The police chief confirmed that after 4:30 p.m., police officers were patrolling and unable to continuously monitor cameras.

In the *Care and Oversight Deficiencies* report, the OIG found that Pharmacy Service was not utilizing the VHA-required Pharmacy Service medication management system to record ward pharmacy stock for inventory accountability, and that identification of inventory trends was an informal process that relied on Pharmacy Service staff to recognize and report unusual use.[117] The OIG determined that the Pharmacy Service's non-standardized and informal tracking

[114] An example of how this information might be useful is if death dispositions keep being referred to a particular service line, the workgroup might benefit in knowing what type of findings are coming back from that service line or if the quality of the analyses was adequate.

[115] Facility SOP, *Mortality Review*.

[116] VA Handbook 0730, *Security and Law Enforcement,* August 11, 2000.

[117] The Veterans Health Information Systems and Technology Architecture Automatic Replenishment system is a Pharmacy Service Medication management system used to electronically track drug distribution within the facility.

process was inadequate and contributed to a lack of situational awareness that a large amount of a key rescue medication was depleted from the same area within a short period of time.[118]

In August 2021, the OIG learned through an interview, that VHA amended the medication tracking guidance. Facility staff in areas using automated dispensing cabinets with tracking software, such as Pyxis™ units, were not required to use the Veterans Health Information Systems and Technology Architecture Automatic Replenishment System (replenishment system). However, the facility implemented the replenishment system within areas not utilizing system inventory tracking software.[119]

The OIG found through interviews and document reviews that the facility implemented a Rescue Medication Review Process policy that included the daily reconciliation of rescue medications removed from the automated dispensing cabinets.[120] In addition, electronic health records reviews and findings were tracked, trended, and reported to facility leaders. Concerns or deviations were reported in the Joint Patient Safety Reporting system and reported to the ADPCS or designee. The OIG reviewed available Quality Executive Council minutes from November 2020 through July 2021 and found, in general, that the facility was following its Rescue Medication Review Process policy.

Personnel-Related Issues and Background Investigation Adjudication

The *Care and Oversight Deficiencies* report reflected that an administrative investigation board, completed in December 2020, recommended appropriate actions (administrative) be considered for facility leaders and select ward 3A clinical staff. As discussed previously, the entire leadership team and the Chief of Quality Management turned over, and at the time of the review, all of the positions were filled by employees assigned on a temporary basis. In addition, the OIG was told that the ward 3A nurse manager and assistant nurse manager positions were filled by "acting[s]," and only 8 of 13 hospitalist positions were filled by providers who were actively seeing patients at the time of the OIG review. The OIG was told that recruitment efforts were

[118] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021. One ampule of Dextrose Solution 50 percent (D50) is a common treatment for hypoglycemia and typically raises the blood glucose level within minutes. Recurrent episodes of hypoglycemia necessitating repeated doses of D50 over a short period of time is atypical. A patient receiving 16 ampules of D50 in a 29-hour period should have prompted an evaluation in this case, but it did not.

[119] VHA Directive 1108.06(1), *Inpatient Pharmacy Services*, February 8, 2017, amended June 21, 2021.

[120] Facility Policy 119-41, *Rescue Medication Review Process*, October 13, 2020. The policy outlines the process for reviewing used rescue medications. D50 is considered a rescue medication, stored in the Pyxis units, and included in the review process. The OIG directed recommendation 13 to the Under Secretary for Health, "The Under Secretary for Health determines the potential advantage of a rescue medication flagging system as an additional tool to evaluate unexplained adverse patient events, including but not limited to mortalities, and takes action as indicated."

ongoing. Cultural transformation to a patient-centric environment that prioritizes patient safety is dependent on a stable and unified leadership team.

The *Care and Oversight Deficiencies* report reflected that the nursing assistant's background investigation was not adjudicated for employment suitability during the four years she worked at the facility. Her case, along with others, was placed on VHA's "delinquent" adjudication list.[121] On December 2, 2019, VHA's Deputy Under Secretary for Health for Operations and Management issued guidance requiring VISN dissemination of delinquent adjudications to their respective facilities and quarterly reporting to VHA's Personnel Security and Credentialing Program Office on the status of remediation efforts to address those cases.[122] The Under Secretary for Health, in addressing a related recommendation, acknowledged "longstanding retention issues" in personnel security, and commented that efforts were underway to ensure that "work in the vetting arena is adequately resourced."

In August 2021, the OIG was told that the facility had two employees assigned to personnel security, covering both background adjudications and personal identity verification card activities. Two additional employee selections were pending, one with an estimated entrance-on-duty date of August 2021. The OIG was told that, as of mid-August, there were 53 background adjudications on the facility's delinquency list. The VISN-level Supervisory Personnel Security Specialist told the OIG that the facility was challenged in managing the workload in the context of limited staffing.

Further, despite VHA's 2019 guidance requiring at least quarterly follow-up and reporting to the Personnel Security and Credentialing Program Office, the OIG learned that the facility had not received an adjudication delinquency list since January 2020. The VISN-level Supervisory Personnel Security Specialist, who was new to the role in 2021, told the OIG of regularly receiving and reviewing the list but not providing it to the facilities for action.

Hospice and Palliative Care Program

The *Care and Oversight Deficiencies* report noted that the facility's Palliative Care Consult Team (PCCT) lacked a dedicated physician or other mid-level provider and did not include routine participation of the psychologist, chaplain, or other disciplines, as outlined in VHA policy.[123] The PCCT Nurse Coordinator was completing 100 percent of the hospice consults, although VHA requires a physician or non-physician practitioner with physician collaborator to complete consults.[124] Further, because the PCCT was not fully staffed or functional, it was

[121] The facility's current adjudicator told the OIG inspection team of completing more than 150 backlogged cases after finishing the adjudication training.

[122] VHA 10N Memorandum, *Notification of Delinquent Background Investigation Adjudications*, December 2, 2019.

[123] VHA Directive 1139, *Palliative Care Consult Teams (PCCT) and VISN Leads*, June 14, 2017.

[124] VHA Directive 1139.

unclear to the OIG how the facility's hospice utilization could be significantly higher than like-sized facilities.

In August 2021, the OIG learned through interviews that the PCCT continued to operate without the support of a dedicated team. The PCCT Nurse Coordinator was the only dedicated member and continued to complete all of the hospice and palliative care consults, which was contrary to policy.[125] The Associate Chief of Staff for Primary and Specialty Care explained that "We have had an open continuous position for [a] hospice/palliative care physician for approximately 10 months, which has been present on usajobs.gov. In that time frame, we have had two candidates [who both] declined the position."

The Associate Chief of Staff for Primary and Specialty Care also said that the facility's academic affiliate had the ability to provide a 0.3 full-time equivalent provider for an outpatient hospice and palliative care program with an anticipated start date of October 2021.[126] According to the PCCT Nurse Coordinator, a goal for the program was to establish a palliative care outpatient program. However, a part-time provider in the outpatient hospice and palliative care setting does not resolve the PCCT's noncompliance with VHA requirements for PCCT staffing.

Regarding concerns about hospice utilization rates, the acting COS told the OIG of discontinuing a previous practice of asking all patients being admitted to the hospital if they were interested in hospice.[127] The OIG compared hospice utilization data from FYs 2017 and 2018 with hospice utilization data over the same quarters in FYs 2020 and 2021. The OIG confirmed that the facility's recent hospice utilization was more closely aligned with other VISNs and similar complexity facilities.

Status and Conclusion

As of September 27, 2021, the facility submitted an update reflecting additional corrective actions and progress to address OIG recommendations. Based on this information, the OIG was able to close recommendation 3 (not included in table A.1).

Since publication of the May 2021 report, the facility has made improvements in several areas including medication-related security and tracking processes, reporting of patient safety events, and staff education and training. While improvements have been slower to take shape in other areas described in this report, the OIG RRT found that corrective actions were being taken and progress was being made in implementing OIG recommendations. Additional time and oversight

[125] VHA Directive 1139.

[126] Congressional Research Service, *Federal Workforce Statistics Sources: OPM and OMB*, updated June 24, 2021. Full-time equivalent equals 2,080 hours of work per year. This term is used to describe the number of hours worked rather than the number of individual employees.

[127] The OIG acknowledges there are instances when it is appropriate to ask patients or families on the day of hospital admission about their interest in hospice; however, the discussion of end-of-life care may not be appropriate for those patients who seek treatment for temporary or self-limited conditions.

are needed to fully evaluate whether those actions have been effective in addressing and remediating the deficient conditions. The OIG will follow up on the remaining 14 recommendations through its quarterly monitoring process.

Appendix B: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines five OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Medical Center Director, COS, and ADPCS. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table B.1. Summary Table of Recommendations

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

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• None	• The Director designates a systems redesign and improvement coordinator. • The COS regularly attends Surgical Work Group meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• Referring physicians complete all required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent prior to patient transfer. • Nurse-to-nurse communication occurs between sending and receiving facilities.	• None

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

Appendix C: Medical Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated medical center reporting to VISN 5.[1]

Table C.1. Profile for Louis A. Johnson VA Medical Center (540) (October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
Total medical care budget	$207,388,188	$205,912,839	$242,697,255
Number of: • Unique patients	22,113	22,223	21,284
• Outpatient visits	319,848	336,696	290,605
• Unique employees§	1,042	1,078	1,148
Type and number of operating beds: • Community living center	30	38	38
• Domiciliary	15	25	30
• Medicine	41	33	33
• Mental health	10	10	10
• Surgery	7	7	7
Average daily census: • Community living center	23	24	16
• Domiciliary	14	15	7
• Medicine	18	16	16
• Mental health	5	5	5

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

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
• Surgery	2	2	1

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

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

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

†*October 1, 2018, through September 30, 2019.*

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

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

Appendix D: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Parsons, WV	540GA	2,021	103		–	Nutrition Pharmacy Social work
Parkersburg, WV	540GB	7,221	2,416	Dermatology Endocrinology	–	Nutrition Pharmacy Social work
Gassaway, WV	540GC	3,110	476	Dermatology	–	Nutrition Pharmacy Social work

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

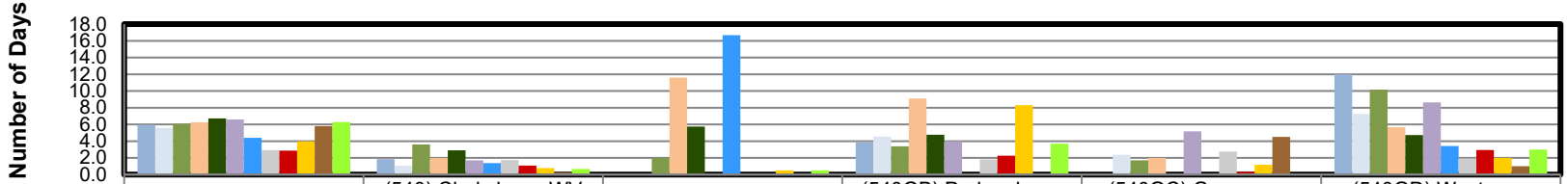
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Westover, WV	540GD	3,313	2,547		–	Nutrition Pharmacy Social work

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

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

Appendix E: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days



	All VHA	(540) Clarksburg, WV (Louis A. Johnson)	(540GA) Parsons, WV	(540GB) Parkersburg, WV	(540GC) Gassaway, WV	(540GD) Westover, WV
JUL-FY20	5.9	1.9	n/a	3.8	0.0	12.0
AUG-FY20	5.6	1.1	0.0	4.5	2.4	7.3
SEP-FY20	6.1	3.6	2.0	3.4	1.7	10.2
OCT-FY21	6.3	2.0	11.6	9.1	2.0	5.7
NOV-FY21	6.7	2.9	5.8	4.8	0.0	4.7
DEC-FY21	6.6	1.7	0.0	4.0	5.2	8.6
JAN-FY21	4.4	1.4	16.7	0.0	0.0	3.4
FEB-FY21	2.9	1.7	0.0	1.8	2.8	1.9
MAR-FY21	2.9	1.1	0.0	2.3	0.3	2.9
APR-FY21	4.0	0.8	0.5	8.3	1.2	2.0
MAY-FY21	5.8	0.2	0.0	0.0	4.5	1.0
JUN-FY21	6.3	0.7	0.5	3.7	n/a	3.0

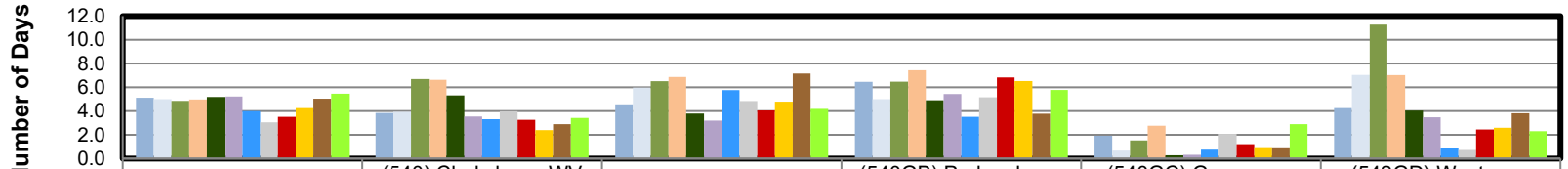
Source: VHA Support Service Center.

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

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

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	All VHA	(540) Clarksburg, WV (Louis A. Johnson)	(540GA) Parsons, WV	(540GB) Parkersburg, WV	(540GC) Gassaway, WV	(540GD) Westover, WV
JUL-FY20	5.1	3.8	4.6	6.5	1.9	4.3
AUG-FY20	5.0	3.9	6.0	5.0	0.7	7.0
SEP-FY20	4.9	6.7	6.5	6.5	1.5	11.3
OCT-FY21	5.0	6.6	6.9	7.4	2.8	7.0
NOV-FY21	5.2	5.3	3.8	4.9	0.3	4.0
DEC-FY21	5.2	3.5	3.2	5.4	0.3	3.5
JAN-FY21	4.0	3.3	5.8	3.5	0.8	0.9
FEB-FY21	3.1	4.0	4.9	5.2	2.1	0.7
MAR-FY21	3.5	3.3	4.1	6.8	1.2	2.5
APR-FY21	4.3	2.4	4.8	6.5	1.0	2.6
MAY-FY21	5.0	2.9	7.2	3.8	1.0	3.8
JUN-FY21	5.5	3.4	4.2	5.8	2.9	2.3

Source: VHA Support Service Center.

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

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

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

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use engmt	Sharing and use of All Employee Survey (AES) data	A higher value is better than a lower value
Behavioral health (BH90)	Healthcare Effectiveness Data and Information Set (HEDIS) outpatient performance measure composite related to screening for depression, posttraumatic stress disorder, alcohol misuse, and suicide risk	A higher value is better than a lower value
Care transition (HCAHPS)	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
Diabetes (DMG90_ec)	HEDIS outpatient performance measure composite for diabetes care	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	Healthcare associated infections	A lower value is better than a higher value
Hospital rating (HCAHPS)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Inpt global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value

Measure	Definition	Desired Direction
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	A higher value is better than a lower value
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH population coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	Care coordination (patient-centered medical home (PCMH))	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value

Measure	Definition	Desired Direction
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH survey)	A higher value is better than a lower value
Tobacco & Cessation (SMG90_1)	HEDIS outpatient performance measure composite related to tobacco screening and cessation strategies	A lower value is better than a higher value

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix H: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 13, 2022

From: Director, VA Capitol Health Care Network (10N5)

Subj: Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia

To: Director, Office of Healthcare Inspections (54CH03)

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

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG's) draft report entitled - Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.

2. I have reviewed the attached comments provided by the Medical Center Director, Louis A. Johnson VA Medical Center and concur with the request for closure of recommendations #1 and 2. Furthermore, I concur with the submitted actions for recommendations #3, 4, and 5.

3. Should you require any additional information please contact VISN 5 network office.

(Original signed by:)

Robert M. Walton, FACHE

Appendix I: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: January 10, 2022

From: Director, Louis A. Johnson VA Medical Center (540/00)

Subj: Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia

To: Director, VA Capitol Health Care Network (10N5)

1. Thank you for the opportunity to provide a response to the findings from the Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center.

2. I concur with the recommendations and have submitted supporting documentation to request closure for recommendations one and two for consideration.

3. I will ensure the actions to correct any remaining open findings are completed and sustained as described in the responses. I appreciate the opportunity for this review as a continuing process to improve care to our Veterans.

(Original signed by:)

Barbara Forsha

OIG Contact and Staff Acknowledgments

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