DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 6: VA Mid-Atlantic Health Care Network in Durham, North Carolina

CHIP REPORT | REPORT #21-00237-114 | MARCH 29, 2022

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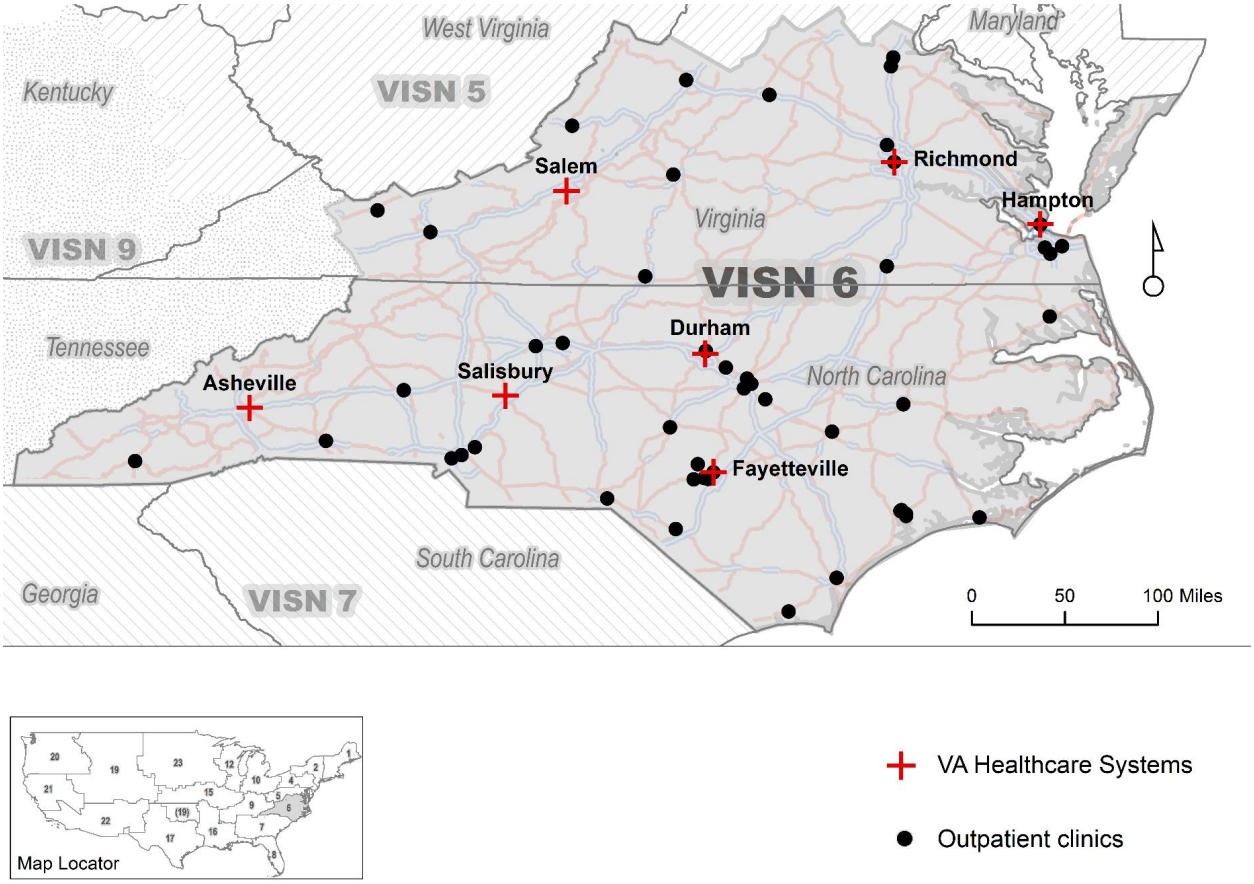

Figure 1. *Veterans Integrated Service Network 6: VA Mid-Atlantic Health Care Network.*
Source: Veterans Affairs Site Tracking Database (accessed June 8, 2021).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
CNO	chief nursing officer
ED	emergency department
FTE	full-time equivalent
FY	fiscal year
HCS	Health Care System
HRO	human resources officer
OIG	Office of Inspector General
QMO	quality management officer
SAIL	Strategic Analytics for Improvement and Learning
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by the Veterans Integrated Service Network (VISN) 6: VA Mid-Atlantic Health Care Network in Durham, North Carolina. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

The OIG conducted this unannounced virtual inspection during the week of May 10, 2021. The OIG also performed virtual inspections of the following VISN 6 facilities during the weeks of May 3 and 10, 2021:

- Charles George VA Medical Center (VAMC) (Asheville, North Carolina)
- Durham VA Health Care System (North Carolina)
- Fayetteville VA Coastal Health Care System (North Carolina)
- Hampton VAMC (Virginia)
- Hunter Holmes McGuire VAMC (Richmond, Virginia)

[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)."

- Salem VAMC (Virginia)
- W.G. (Bill) Hefner VAMC (Salisbury, North Carolina)

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. The findings presented in this report are a snapshot of VISN 6 and facility performance within the identified focus areas at the time of the OIG inspection. The findings may help VISN leaders identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the VISN leadership team consisted of the acting Network Director, acting Deputy Network Director, acting Chief Medical Officer, and Chief Nursing Officer. Additional VISN leaders included the Quality Management Officer and acting Human Resources Officer, who reported to the Chief Nursing Officer and Director, respectively. The VISN managed organizational communication and accountability through a committee reporting structure. Within this structure, the VISN's Executive Leadership Council oversaw the Organizational Health; Quality, Safety & Value; Healthcare Delivery; and Healthcare Operations Committees.

The acting Network Director and acting Chief Nursing Officer had served for about four and six months, respectively, at the time of the OIG virtual inspection; the acting Deputy Network Director had served for two years. The Chief Nursing Officer was assigned in 2017 but started as the VISN Quality Management Officer in 2010.

The OIG reviewed selected employee satisfaction and patient experience survey results. The OIG concluded that VISN leaders were engaged and promoted a culture where employees felt safe bringing forward issues and concerns. Although scores were not attributable to the acting Network Director, opportunities appeared to exist to improve employee perceptions of servant leadership and reduce feelings of moral distress in the workplace.[2] The OIG found lower patient

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

experience survey scores when compared to Veterans Health Administration (VHA) averages, indicating that patients were less satisfied with the care provided.

The OIG also evaluated VISN access metrics and clinical vacancies. The inspection team identified potential organizational risks at some facilities with extended average wait times and clinical vacancies in certain specialties.

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[3] Leaders were knowledgeable, within their scope of responsibilities, about selected SAIL and Community Living Center SAIL measures. However, the OIG identified that the acting Network Director, acting Chief Medical Officer, and Quality Management Officer had opportunities to improve their oversight of facility-level quality, safety, and value; care coordination; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

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

Medical Staff Credentialing

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

Environment of Care

The OIG observed compliance with most environment of care elements. However, the inspection team identified weaknesses with quarterly Emergency Management Committee meetings and the committee's review of VISN-wide strengths, weaknesses, priorities, and requirements for improvement.

Women's Health

The VISN complied with requirements for the establishment of a multidisciplinary team to execute strategic planning activities, monthly calls with facility women veterans program leaders, access and satisfaction data analyses, and VISN-level support staff availability.

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

However, the OIG identified weaknesses with annual facility site visits and staff education gap assessments.

Conclusion

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

VA Comments

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

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Assistant Inspector General
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Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 6: VA Mid-Atlantic Health Care Network. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so they can make informed decisions to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[1] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[2]

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual inspection and initiated a pandemic readiness and response evaluation. As such, to examine risks to patients and the organization, the OIG focused on core processes in the following areas of administrative and clinical operations.[3]

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

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

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

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

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

Methodology

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

The inspection examined operations from April 1, 2017, through May 14, 2021, the last day of the unannounced multiday virtual inspection.[5]

The OIG also performed virtual inspections of the following VISN 6 facilities during the weeks of May 3 and 10, 2021:

- Charles George VA Medical Center (VAMC) (Asheville, North Carolina)
- Durham VA Health Care System (HCS) (North Carolina)
- Fayetteville VA Coastal HCS (North Carolina)
- Hampton VAMC (Virginia)
- Hunter Holmes McGuire VAMC (Richmond, Virginia)
- Salem VAMC (Virginia)
- W.G. (Bill) Hefner VAMC (Salisbury, North Carolina)

The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 6 jurisdiction 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.[6] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[5] The range represents the time from the completion of the Clinical Assessment Program review of the W.G. (Bill) Hefner VAMC, which began March 27, 2017, to the completion of the unannounced multiday virtual CHIP visit in May 2021 (see appendix D).

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can affect the ability to provide care in the clinical focus areas.[7] To assess this VISN's risks, the OIG considered the following indicators:

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

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility virtual CHIP visits performed during the weeks of May 3 and 10, 2021.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among medical facilities, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is the basic budgetary and planning unit of the veterans' healthcare system.[8]

VISN 6 leaders oversee seven medical facilities and 34 associated outpatient clinics in North Carolina and Virginia. The network has over 19,000 full-time equivalent (FTE) clinical and support staff. Additionally, about 4,000 volunteers serve over 415,000 veterans in the network each year. VISN 6 is home to more than 500 researchers and is affiliated with seven major medical schools and over 50 colleges and universities. According to data from the VA National

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

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

Center for Veterans Analysis and Statistics, the VISN had a veteran population of 1,185,550 within its borders at the beginning of fiscal year (FY) 2021 and a projected population of 1,169,418 by the end of FY 2022. The VISN's FY 2020 annual medical care budget of $4,845,699,987 increased by 24 percent compared to the previous year's budget of $3,901,140,962.

The OIG recognizes that the COVID-19 pandemic caused significant and widespread changes in the delivery of healthcare services.[9] As a result, productivity data and supporting reports may require further analysis to reach specific actionable conclusions.

VISN 6 had a leadership team consisting of the acting Network Director, acting Deputy Network Director, acting Chief Medical Officer (CMO), and Chief Nursing Officer (CNO). The CMO oversaw facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.[10]

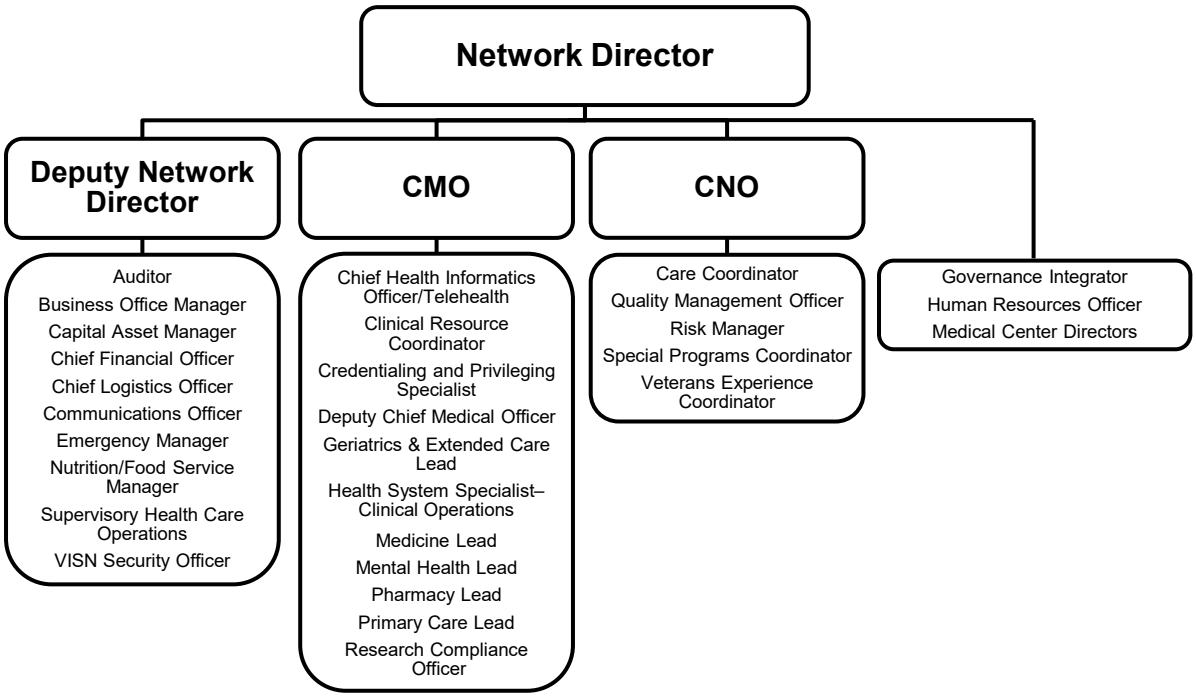


Figure 2. *VISN 6 organizational chart.*

Source: VA Mid-Atlantic Health Care Network (received May 10, 2021).

[9] "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)."

[10] For this VISN, the acting Network Director is responsible for the directors of the Charles George VAMC (Asheville, North Carolina), Durham VA HCS (North Carolina), Fayetteville VA Coastal HCS (North Carolina), Hampton VAMC (Virginia), Hunter Holmes McGuire VAMC (Richmond, Virginia), Salem VAMC (Virginia), and W.G. (Bill) Hefner VAMC (Salisbury, North Carolina).

At the time of the OIG virtual inspection, the VISN's leadership team had worked together for about four months. Three of the four leadership positions were filled by acting personnel. The acting Network Director, the newest member of the team, was assigned in January 2021. The acting Deputy Network Director had served in the role for almost two years, and the acting CMO for six months. The CNO, the most tenured and only permanently appointed executive leader, came to the VISN as the Quality Management Officer (QMO) in 2010 and was assigned as the CNO in 2017 (see table 1). Additional VISN leaders included the QMO, who reported to the CNO and was assigned in 2019, and acting Human Resources Officer (HRO), who reported to the Director. The acting HRO had served in that capacity since being detailed to the VISN in November 2020.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	January 1, 2021 (acting)
Deputy Network Director	June 23, 2019 (acting)
Chief Medical Officer	November 1, 2020 (acting)
Chief Nursing Officer	March 5, 2017

Source: VA Mid-Atlantic Health Care Network (received May 11, 2021).

As reported by the local media, the previous Network Director, who retired in January 2021, experienced public disagreements with other VISN staff.[11] The public nature of these disagreements affected VISN leadership stability. At the time of the OIG visit, the deputy network director and human resource officer positions were encumbered and filled by acting staff.[12] The current executive leaders stated that VISN staff managed operations well during the COVID-19 pandemic but had lingering concerns about the uncertainty of when the senior leadership positions would be permanently filled.

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

- providing organizational values and strategic direction,
- developing policy and making decisions,

[11] Nick Ochsner, "WBTV Investigates: Second whistleblower details allegations of harassment, retaliation by senior VA official amid inaction by whistleblower protection office," *WBTV*, November 21, 2019, https://www.wbtv.com/2019/11/22/second-whistleblower-details-allegations-harassment-retalation-by-senior-va-official-amid-inaction-by-whistleblower-protection-office/. Nick Ochsner, "WBTV Investigates: VA whistleblower complaints allege abuse, retaliation from regional director," *WBTV*, January 18, 2019, https://www.wbtv.com/2019/01/19/va-whistleblower-complaints-allege-abuse-retaliation-regional-director/.

[12] Encumbered positions give employees rights to return to their previously held positions.

- managing compliance and financial performance,
- reviewing organizational performance and capabilities,
- identifying priorities for improvement and opportunities for innovation, and
- developing and communicating organizational goals and objectives across the network.

The acting Network Director served as the chairperson of the Executive Leadership Council, which had direct oversight of the Organizational Health; Quality, Safety & Value; Healthcare Delivery; and Healthcare Operations Committees (see figure 3).

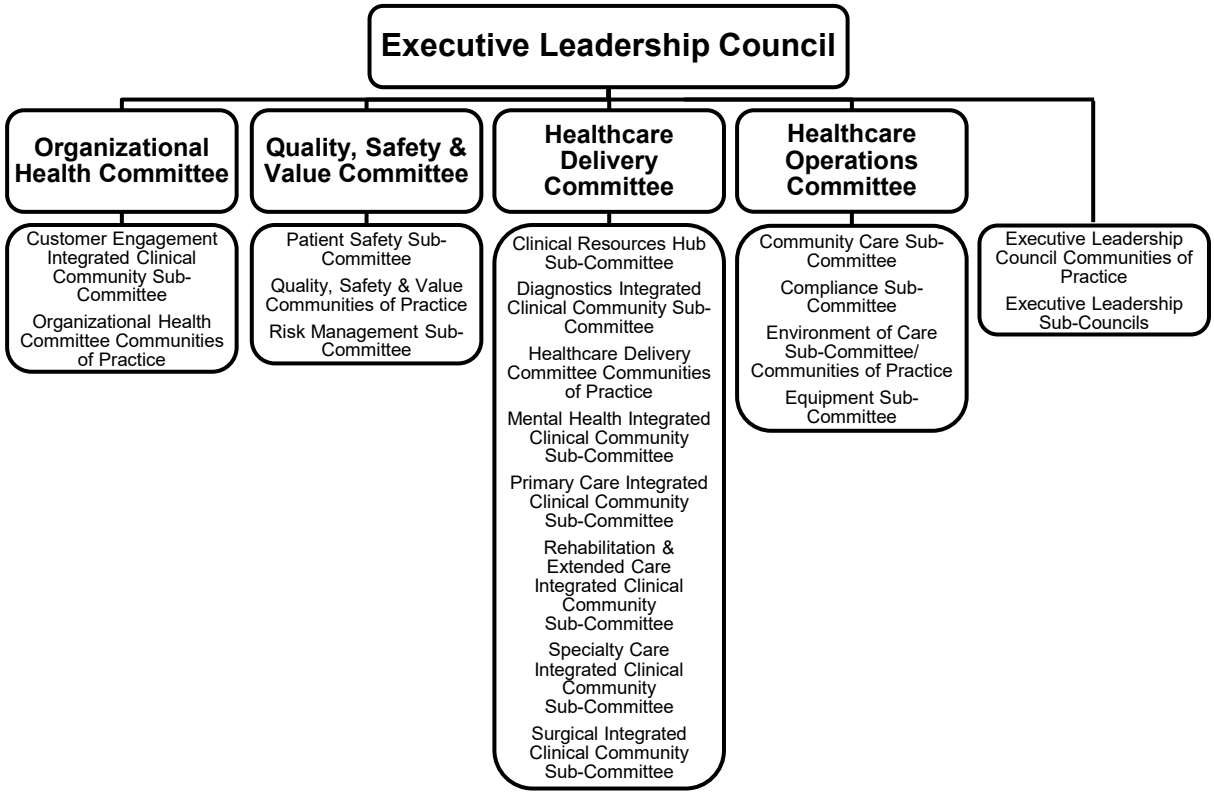


Figure 3. *VISN 6 committee reporting structure.*
Source: VA Mid-Atlantic Health Care Network (received May 5, 2021).

To help assess VISN executive leaders' engagement, the OIG interviewed the acting Network Director, acting Deputy Network Director, acting CMO, Deputy CMO, CNO, QMO, and HRO. The OIG interviewed the leaders about their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the executive leaders were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. Details about these actions are below.

Employee Satisfaction

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

To assess employee attitudes toward VISN leaders, the OIG reviewed VHA All Employee Survey satisfaction results from October 1, 2019, through September 30, 2020.[15] Table 2 summarizes those results. The OIG found the VISN office, Deputy Network Director, CMO, and CNO scores for the selected survey leadership questions were similar to or higher than the VHA averages. Although scores were not attributable to the acting Network Director, opportunities appeared to exist to improve employee perceptions of servant leader behaviors.[16]

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

[14] "AES Survey History."

[15] Ratings are based on responses by employees who reported to or were aligned under the Network Director, Deputy Network Director, CMO, and CNO. The survey results are also not reflective of the CMO, who assumed the role after the survey review period. QMO staff were included in the Director's totals.

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

Table 2. Survey Results on Employee Attitudes toward VISN 6 Leaders (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	VISN 6 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	CNO Average
All Employee Survey: *Servant Leader Index Composite*.*	0–100 where higher scores are more favorable	73.8	78.5	69.0	80.0	97.0	–
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	3.4	3.6	4.1	4.6	3.4
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.6	3.8	4.0	4.6	3.6
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	3.6	4.1	4.6	3.8

Source: VA All Employee Survey (accessed April 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 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The leaders' averages were generally more favorable than the VHA averages, with exception of the Network Director's scores. Although the scores were not attributable to the acting Network Director, an opportunity appeared to exist to reduce employees' perceptions of moral distress in the workplace. Executive leaders reported sharing survey results with staff and creating employee workgroups to identify improvement goals for the coming year. To improve employee satisfaction, VISN leaders reportedly offered workforce development training such as emerging leaders and other management workshops.

Table 3. Survey Results on Employee Attitudes toward the VISN 6 Workplace (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	VISN 6 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	CNO Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.0	4.4	–	4.0
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.0	3.8	3.7	4.6	–
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day) lower is better.	1.4	1.2	2.4	0.4	0.8	0.2

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

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[17] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients felt secure and respected.[18]

[17] "Stand Up to Stop Harassment Now!" Department of Veterans Affairs, accessed December 8, 2020, https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/. (This is an internal website not publicly accessible.) Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

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

Table 4 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. Scores for VISN leaders were consistently higher than VHA averages, except for the Network Director's scores; however, as noted above, these scores are not attributable to the acting Director. Generally, the leaders appeared to promote an environment where discrimination was not tolerated, and staff felt safe bringing up problems and tough issues.

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

Questions/Survey Items	Scoring	VHA Average	VISN 6 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	CNO Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.1	3.8	4.6	4.6	4.4
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.2	3.8	4.6	4.6	4.8
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.0	3.6	4.3	4.6	–

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

Patient Experience

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and support benchmarking its performance against the private sector. VHA collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys.

The OIG reviewed survey responses to three relevant questions that reflect patients' attitudes toward their healthcare experiences from October 1, 2019, through September 30, 2020. Table 5 provides relevant survey results for VHA and VISN 6.[19] The VISN averages for the

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

survey questions were slightly lower than the VHA averages. This indicates that patients were less satisfied with the care provided when compared to VHA patients nationally.

VISN 6 facility scores for the selected survey questions can be found in appendix C. VISN leaders acknowledged lower-than-average scores at the Fayetteville VA Coastal HCS and Hampton VAMC. The OIG found that the Organizational Health Committee tracked patient satisfaction scores and reported to the Executive Leadership Council. Leaders stated that from October 2017 through March 2021, the VISN's Veterans Signals trust scores consistently improved from 86.4 to 89.6.[20] Over the same time frame, the Fayetteville VA Coastal HCS and Hampton VAMC Veterans Signals trust scores improved from 81.8 to 86.4 and 78 to 85.8, respectively.

Table 5. Survey Results on Patient Attitudes within VISN 6 (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA Average	VISN 6 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	67.8
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 "Agree" and "Strongly Agree" responses.	82.5	81.1
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.8	83.8

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

Access to Care

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

[20] Department of Veterans Affairs, "VA Customer Profile and Veterans Signals programs recognized by FedHealthIT," *VAntage Point* (blog), June 18, 2019. "The VSignals [Veterans Signals] platform gathers feedback from Veterans, eligible dependents, caregivers and survivors. It then provides the feedback to VA for process improvement, but also sends that feedback directly to the point of interaction to enable resolution."

appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[21] VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates.[22] Wait time measures based on "create date" have the advantage of not relying on the accuracy of the "preferred date" entered into the scheduling system. These measures are particularly applicable for new primary care patients where the care is not initiated by a referral or consultation that includes a "clinically indicated date."[23] The disadvantage to "create date" metrics is that wait times do not account for specific patient requests or availability.[24] Wait time measures based on patient preferred dates consider patient preferences but rely on appointment schedulers accurately recording the patients' wishes into the scheduling software.[25]

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[26] However, with the enactment of the VA MISSION Act on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[27]

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

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

[22] "Completed Appointments Cube Data Definitions," VA Business Intelligence Office, accessed March 28, 2019, https://bioffice.pa.cdw.va.gov/. (This is an internal website not publicly accessible.)

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

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

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

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

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

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

To examine access to primary and mental health care within VISN 6, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 6 and 7 provide wait time statistics for completed appointments from January 1 through March 31, 2021.[28]

Table 6. Primary Care Appointment Wait Times (January 1 through March 31, 2021)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VISN 6	14,826	16.4
Charles George VAMC (Asheville, NC)	1,211	13.9
Durham VA HCS (NC)	672	19.9
Fayetteville VA Coastal HCS (NC)	3,516	19.1
Hampton VAMC (VA)	3,496	16.4
Hunter Holmes McGuire VAMC (Richmond, VA)	2,790	14.1
Salem VAMC (VA)	648	12.2
W.G. (Bill) Hefner VAMC (Salisbury, NC)	2,493	16.3

Source: VHA Support Service Center (accessed April 12, 2021).

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

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

Table 7. Mental Health Appointment Wait Times (January 1 through March 31, 2021)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VISN 6	1,257	13.1
Charles George VAMC (Asheville, NC)	81	13.1
Durham VA HCS (NC)	112	17.5
Fayetteville VA Coastal HCS (NC)	190	11.0
Hampton VAMC (VA)	220	13.4
Hunter Holmes McGuire VAMC (Richmond, VA)	214	8.0
Salem VAMC (VA)	106	12.6
W.G. (Bill) Hefner VAMC (Salisbury, NC)	334	14.8

Source: VHA Support Service Center (accessed April 12, 2021).

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

Based on wait times alone, the MISSION Act may improve access to primary care for patients in the Durham VA and Fayetteville VA Coastal HCSs, where the average wait time for new primary care appointments was 19.9 and 19.1 days, respectively. The wait times highlight opportunities for these facilities to improve the timeliness of "in house" primary care and decrease the potential for fragmented care among patients referred to community providers.

The VISN's overall average wait time for mental health appointments was 13.1 days, and the longest wait time was 17.5 days (Durham VA HCS). According to VISN leaders, implementation of the MISSION Act has increased wait times in rural areas, and the COVID-19 pandemic has increased wait times overall.

VISN leaders stated that staffing and recruitment issues in the rural coastal and western counties of North Carolina contributed to access challenges at the Durham VA and Fayetteville VA Coastal HCSs. To improve access in rural areas, the VISN has staffed a Clinical Resource Hub with providers who deliver virtual care to patients through VA Video Connect.[29] The W.G. (Bill) Hefner VAMC is the hub for virtual mental health care and the Hunter Holmes McGuire VAMC is the hub for virtual primary care. VISN leaders monitor the use of VA Video Connect for appointments by facility. Leaders also track providers' completion of VA Video Connect training and include this in their performance pay.

[29] Department of Veterans Affairs, "VA Video Connect," accessed November 3, 2021, https://mobile.va.gov/app/va-video-connect. "VA Video Connect allows Veterans and their caregivers to quickly and easily meet with VA health care providers through live video on any computer, tablet, or mobile device with an internet connection."

The VISN 6 Strategic Planner reported changes to medical facilities since January 2020:

- The main facility's Emergency Department (ED) reopened in Fayetteville, NC
- An outpatient clinic opened in Jacksonville, NC
- An outpatient clinic opened in Raleigh, NC
- An outpatient clinic opened in Portsmouth, VA
- Six inpatient psychiatric beds were added in Salisbury, NC

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover—or instability—and high clinical vacancy rates negatively affect access to care, quality, patient safety, and patient and staff satisfaction. Turnover can reduce employee and organizational performance through the loss of experienced staff.[30]

To assess the extent of clinical vacancies across VISN 6 facilities, the OIG held discussions with the acting HRO and reviewed the total number of vacancies by facility, position, service or section, and FTE employees. Table 8 provides the vacancy rates across the VISN as of May 10, 2021.

Table 8. Reported Vacancy Rates for VISN 6 Facilities (as of May 10, 2021)

Facility	Clinical Vacancies (FTE)	Clinical Vacancy Rate (%)	Total Vacancy Rate (%)
VISN 6	1144.8	13.4	14.4
Charles George VAMC (Asheville, NC)	65.9	7.2	10.4
Durham VA HCS (NC)	171.2	11.0	13.1
Fayetteville VA Coastal HCS (NC)	187.4	18.4	16.5
Hampton VAMC (VA)	189.5	17.9	18.5
Hunter Holmes McGuire VAMC (Richmond, VA)	245.4	13.2	15.2
Salem VAMC (VA)	80.5	11.3	11.7
W.G. (Bill) Hefner VAMC (Salisbury, NC)	204.9	14.4	14.0

Source: VISN 6 HRO (received May 10, 2021).

The OIG found the following FTE primary care clinical vacancies across VISN 6:

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

- Physicians: ~39
- Physician assistants: ~14
- Nurse practitioners: ~16
- Nurses: ~615

Clinical staffing may contribute to wait time challenges at the Durham VA and Fayetteville VA Coastal HCSs. Durham had 7 physician and 97 nurse FTE vacancies. Fayetteville had 10 physician, 1 physician assistant, 9 nurse practitioner, and 87 nurse FTE vacancies.

For mental health, the OIG found the following FTE clinical vacancies across VISN 6:

- Psychiatrists: ~47
- Psychologists: ~47
- Nurses: ~14
- Social workers: ~18

Clinical staffing may contribute to the longer wait times at the Durham VA HCS because 9 psychiatrist, 3 psychologist, and 2 social worker FTE positions were vacant.

Although VISN leaders reported meeting the VA's human resource modernization milestones, the acting HRO discussed efforts to increase overall human resource staffing to better support VISN hiring needs. The acting HRO also reported recruiting challenges in highly rural areas and salary competition with private sector hospitals in metropolitan areas. Vacancy and recruitment data were regularly reported to VISN and facility leaders. VISN leaders used hiring incentives such as pay adjustment by locality, the Education Debt Reduction Program, and recruitment and relocation bonuses.[31] Leaders spent $3,494,400 on relocation, retention, and recruitment bonuses in FY 2020 and $841,001 in FY 2021, through the date of the OIG visit. Education Debt Reduction Program allocations for FY 2021 totaled $4,384,243, with 230 active program participants.

The acting HRO reported hosting a virtual job fair for medical support assistants at the Fayetteville VA Coastal HCS, which resulted in the hiring of 48 new employees. During the COVID-19 pandemic, VISN leaders used VA's rapid hiring processes to increase facility staffing levels. At the time of the OIG inspection, the VISN had an overall net gain of 923 FTE employees for FY 2021.

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

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders responded to identified problems. At the time of the virtual inspection, VISN and facility leaders had completed action plans for all but four recommendations for improvement listed in appendix D.

Veterans Health Administration Performance Data

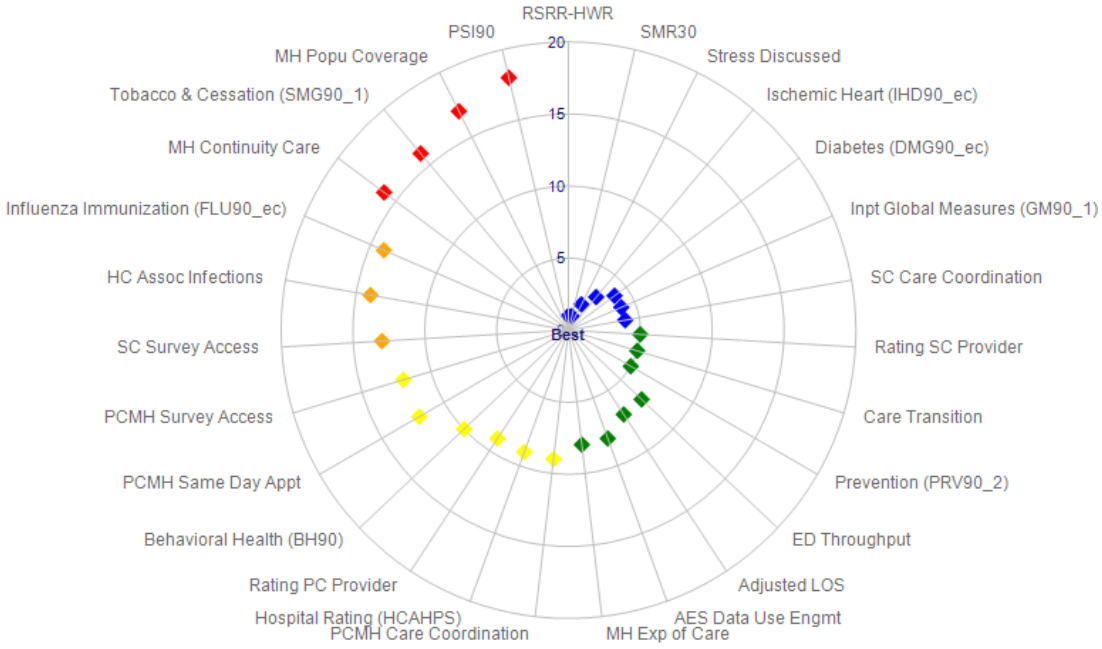
The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[32] Despite noted limitations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

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of December 31, 2020. The figure uses blue and green data points to indicate high performance (for example, in the areas of hospital-wide readmissions (RSRR-HWR), 30-day standardized mortality ratio (SMR30), and care transition). Metrics that need improvement are in orange and red (for example, specialty care (SC) survey access, mental health (MH) population (popu) coverage, and patient safety index scores (PSI90)).[34]

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

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

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



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

Figure 4. *VISN 6 quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 2020).*

Source: VHA Support Service Center.

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

VISN leaders were able to speak in depth about fifth quintile measures. They reported holding monthly Healthcare Operations Committee meetings with facility managers to review performance measures and improvement actions. The OIG found that VISN leaders tracked and monitored patient safety index scores, mental health population coverage, mental health continuity of care, and tobacco cessation efforts.

The SAIL Value Model also includes a community living center (CLC) model, which is a tool to "summarize and compare performance of CLCs in the VA."[35] The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[36]

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

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

Figure 5 illustrates the VISN's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2020. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long-stay (LS), new or worse pressure ulcers (PU)–short-stay (SS), and catheter in bladder (LS)). Measures that need improvement are in orange and red (urinary tract infection (UTI) (LS), outpatient ED visit (SS), and high risk PU (LS)).[37]

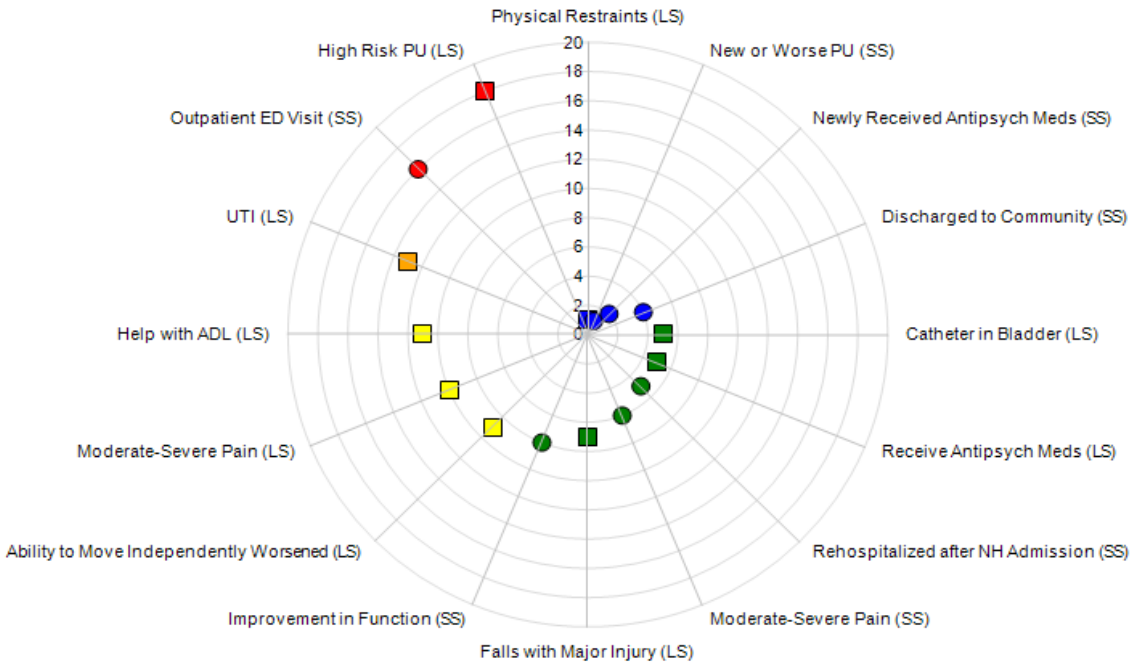


***Figure 5**. VISN 6 CLC quality measure rankings for FY 2020 quarter 4 (as of September 30, 2020).*

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

Source: VHA Support Service Center.

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

The OIG reviewed VISN CLC SAIL data and overall quality scores as of FY 2020 quarter 4. The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to specific poorly performing CLC SAIL measures.

The OIG found that VISN leaders monitored the pressure ulcer and outpatient ED visit performance measures. The Deputy CMO reported that a small number of cases caused a decline in pressure ulcer performance scores. According to the Deputy CMO, a lack of proper admission documentation and inclusion of the spinal cord injury unit contributed to the overall VISN performance. The Deputy CMO also stated that some ED admissions from CLCs occurred at a higher rate when the CLC, with high-acuity patients, was co-located with a VAMC. Further, the

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

Deputy CMO indicated that documentation may have "double counted" an ED visit if the patient presented late in the evening but staff completed final admission paperwork the next business day.

Additionally, the CMO and Deputy CMO reported that VISN leaders made a concerted effort to improve CLC care and that the recently released scores for FY 2021 quarter 1 indicated improvement for all the CLCs. VISN leaders implemented the following actions:

- Monthly CLC meetings to discuss quality measures
- Phased CLC Rapid Cycle Improvement Learning Intensive program[38]
- On-site and virtual mock surveys by CLC staff at sister facilities
- Staff education on Long-Term Care Institute unannounced surveys and training to improve quality care and documentation

Observed Trends in Noncompliance

The OIG identified that the acting Network Director, acting CMO, and QMO had opportunities to improve their oversight of facility-level quality, safety, and value; care coordination; and high-risk processes.

During virtual CHIP visits of the VISN 6 facilities performed during the weeks of May 3 and 10, 2021, the OIG noted trends in noncompliance for the following areas:

- Quality, safety, and value
  - Surgical work group attendance
- Care coordination (inter-facility transfers)
  - Transfer note completion
  - Transmission of active medication lists to receiving facilities
  - Transfer monitoring and evaluation
- High-risk processes (management of disruptive and violent behavior)
  - Committee meeting attendance
  - Staff training

[38] The purpose of the learning intensive program is to assist CLCs in establishing a process of rapid and sustained improvement in quality measures.

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

Leadership and Organizational Risks Conclusion

The VISN experienced leadership turmoil and instability during the year prior to the OIG inspection. At the time of the inspection, the leadership team had worked together for about four months. Three of the four leadership positions were filled by acting personnel. The acting Network Director was the newest member of the leadership team. The CNO, the most tenured member, started as the VISN QMO in 2010 and was assigned as the CNO in 2017. The acting Deputy Network Director had served in the role for almost two years, and the acting CMO had served for six months.

The scores for the selected survey leadership questions for the VISN office, Deputy Network Director, and CMO were generally more favorable than the VHA averages. Although the scores were not attributable to the acting Network Director, opportunities appeared to exist to improve employee perceptions of servant leadership and reduce feelings of moral distress in the workplace. The OIG noted that the VISN patient experience survey scores were slightly lower than the VHA averages. VISN leaders appeared engaged in efforts to improve employee and patient satisfaction. Leaders also seemed to support improvements in patient care by opening clinics to increase access to care, ensuring the availability of telehealth resources for patients, and working with CLC staff to improve the quality of care.

The OIG's review of access metrics and clinical vacancies identified potential organizational risk factors at the Durham VA and Fayetteville VA Coastal HCSs. VISN leaders were knowledgeable within their scope of responsibilities about selected SAIL and CLC SAIL metrics and should continue to take actions to sustain and improve performance.

Further, the OIG identified that the acting Network Director, acting CMO, and QMO had opportunities to improve their facility-level oversight of quality, safety, and value; care coordination; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[39] 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.[40]

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."[41] "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."[42]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's effect on VISN 6 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 will report the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 6 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

[39] "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.

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

[41] 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."

[42] 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.[43] 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.[44] Designated leaders are directly accountable for program integration and communication within their level of responsibility. Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[45]

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

- Designation of a systems redesign and improvement program manager[46]
- Establishment of a systems redesign and improvement advisory group that has representation from each VISN medical center[47]
- Assignment of a chief surgical consultant who also serves as chairperson of the VISN surgical work group[48]
- Designation of a VISN lead surgical nurse who participates in the VISN surgical work group[49]
    - Chairperson of conference calls with VA facility surgical quality nurses
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[50]
    - Monitoring of facility outlier data and communication of follow-up actions to VISN and facility directors

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

  - Submission of quarterly VISN peer review data analysis reports to the Office of Quality, Safety, and Value
- Quarterly reporting of institutional disclosures to the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value[51]

Quality, Safety, and Value Findings and Recommendations

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

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

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[52] When certain actions are taken against a physician's license, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the physician meets licensure requirements for VA employment.[53] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO.[54] The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with VHA policy," which includes VISN CMO oversight of facilities' processes.[55]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[56] When reports from the National Practitioner Data Bank or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

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

[52] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This handbook was in place at the time of the inspection. The credentialing portion of VHA Handbook 1100.19 was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers,* September 15, 2021.)

[53] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (This directive was in place at the time of the inspection. VHA Directive 2012-030 was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers,* September 15, 2021.)

[54] VHA Handbook 1100.19.

[55] VHA Handbook 1100.19.

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

Medical Staff Credentialing Finding and Recommendation

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

VHA policy states that physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review."[57] The physicians' "credentials file must be reviewed with Regional Counsel or designee, [and]… the review and the rationale for the conclusions must be forwarded to the VISN CMO for concurrence and approval of the appointment."[58]

The OIG reviewed profile information for 532 physicians, using publicly available data and VetPro, and did not find evidence that the VISN CMO approved the VA appointment for 3 physicians who had a potentially disqualifying licensure action.[59] In all the following cases, failure to conduct the required review could result in inappropriate hiring decisions that jeopardize the quality of patient care.

One physician, who was hired in August 2019, had a North Carolina license suspended in 2012 and an Illinois license suspended in 2013. The acting CMO stated that information regarding the adverse actions was not provided to the facility until approximately six weeks after the physician was on duty. The acting CMO also stated that the W.G. (Bill) Hefner VAMC's Deputy Chief of Staff did not believe the case met VHA requirements for reporting to the VISN CMO.

Another physician was hired in August 2019 but had a license placed on probation in June 2014. The acting CMO reported speaking to the Deputy Chief of Staff at the W.G. (Bill) Hefner VAMC and being told that the facility's credentialing team did not believe the adverse action warranted further review. Per the acting CMO, the W.G. (Bill) Hefner VAMC's Deputy Chief of Staff explained that the state licensing board did not require public disclosure, and therefore, the action did not meet VHA's requirement for reporting to the VISN CMO.

The last physician was hired in November 2020 and had a license revoked in 1985. The acting CMO did not have additional information on this case. The acting CMO acknowledged understanding that the action warranted a review but expressed not having concerns because it occurred over 30 years ago.

[57] VHA Handbook 1100.19.

[58] VHA Handbook 1100.19.

[59] VHA Handbook 1100.19. "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file." All three cases of physician adverse licensure actions occurred prior to the acting CMO's assignment in November 2020.

Recommendation 1

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

VISN concurred.

Target date for completion: September 2022

VISN response: The Chief Medical Officer (CMO) evaluated the recommendation and did not determine any additional reasons for noncompliance. The CMO and VISN Credentialing & Privileging Manager will provide an educational session to all facility Chief of Staffs, Deputy Chief of Staffs and Credentialing & Privileging Managers. The CMO and Credentialing & Privileging Manager will monitor all VISN 6 hiring actions to ensure the mandated CMO review is completed prior to VA appointment for physicians who had potentially disqualifying licensure actions through the National Practitioner Data Bank report. The VISN Credentialing & Privileging Manager will generate a monthly report of license actions and cross-reference to ensure the presence of a CMO review note for any physician appointments who had potentially disqualifying licensure actions. Data will be collected until 90% compliance has been met for six consecutive months. Results of the audit will be reported to the Healthcare Delivery Committee.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that healthcare facilities provide a safe, clean, and functional environment of care for veterans, their families, visitors, and employees in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[60] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[61] VHA provides policy, mandatory procedures, and operational requirements for implementing an effective supply chain management program at VA healthcare facilities which includes responsibility for VISN-level oversight.[62]

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

- Establishment of a policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee[63]
    - Met at least quarterly
    - Documented an annual review within the previous 12 months
        - Emergency Operations Plan
        - Continuity of Operations Plan
        - Hazards Vulnerability Analysis
    - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval

[60] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016, was in place at the time of the inspection. It was rescinded and replaced by VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.) VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[61] VHA Directive 1608.

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

[63] VHA Directive 0320.01.

- Assessed inventory management programs through an annual quality control review[64]

Environment of Care Findings and Recommendations

The VISN complied with most requirements for a comprehensive environment of care program. However, the inspection team identified weaknesses with quarterly Emergency Management Committee meetings and the committee's review of VISN-wide strengths, weaknesses, priorities, and requirements for improvement.

VHA requires VISN leaders to establish an Emergency Management Committee that meets at least quarterly.[65] The OIG did not find evidence of Emergency Management Committee quarterly meetings. This may have resulted in a lack of communication regarding VISN emergency management needs. The OIG received Emergency Management Committee meeting minutes for September and December 2020, and March 2021. The Emergency Manager explained that the previous manager left in December 2019 and various individuals had filled the position until February 2020. The Emergency Manager also described starting in an interim capacity in a 0.25 FTE position in February 2020 while serving as the Emergency Manager for the W.G. (Bill) Hefner VAMC, which led to difficulty holding quarterly VISN meetings. The acting Deputy Network Director reported rewriting the position and hiring the Emergency Manager as a full-time employee in June 2020. The acting Deputy Network Director stated that prior to the COVID-19 pandemic, VISN leaders recognized the need to have a full-time emergency manager position and started rebuilding the emergency management program.

Recommendation 2

2. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that the Veterans Integrated Service Network's Emergency Management Committee meets at least quarterly.

[64] VHA Directive 1761(2).

[65] VHA Directive 0320.01.

VISN concurred.

Target date for completion: December 1, 2022

VISN response: The Network Director evaluated the recommendation and did not determine any additional reasons for noncompliance. The VISN Emergency Manager will ensure that the VISN Emergency Management Committee meets at least quarterly. The Deputy Network Director will monitor to ensure the committee meets quarterly as scheduled and reports compliance to the Healthcare Operations Committee. Committee meetings will be monitored until the committee has met quarterly for four consecutive quarters.

VHA requires VISNs to conduct, document, and send an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval.[66] The OIG did not find evidence of the Emergency Manager's annual review of VISN-wide strengths, weaknesses, priorities, and requirements for improvement. Insufficient communication to VISN leaders could prevent oversight of emergency management readiness. The Emergency Manager stated that the annual review was not a high priority because the position was previously only a 0.25 FTE but discussed plans to present the FY 2021 review in September 2021. The acting Deputy Network Director and Emergency Manager explained that since the position was now full-time, they were able to address emergency management program issues.

Recommendation 3

3. The Network Director evaluates and determines any additional reasons for noncompliance and ensures the Emergency Manager completes an annual review of the collective Veterans Integrated Service Network-wide strengths, weaknesses, priorities, and requirements for improvement.

VISN concurred.

Target date for completion: September 30, 2022

VISN response: The Network Director evaluated the recommendation and did not determine any additional reasons for noncompliance. The VISN Emergency Manager completed the fiscal year 2021 "Annual Emergency Management Program Review" on October 1, 2021. The report was submitted to the Emergency Management Committee and Network Director. The Deputy Network Director will ensure the Emergency Manager completes and presents the fiscal year 2022 "Annual Emergency Management Program Review" to the Network Director.

[66] VHA Directive 0320.01.

Mental Health: Suicide Prevention

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[67] 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.[68] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[69]

VHA requires VISN leaders to appoint mental health staff to serve as a member of its primary governing body, participate on each state's suicide prevention council or workgroup, and coordinate activities with state and local mental health systems and community providers.[70]

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

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

Mental Health Findings and Recommendations

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

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

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

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

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when their needs can be better managed at another facility.[71]

When VA or non-VA staff transfer a patient "to a VA facility in a manner that violates [VA] policy," the VISN CMO is responsible for contacting the transferring facility and conducting a fact-finding review to determine if the transfer was appropriate.[72] Examples of patient transfers that do not comply with VA policy include

- patients who were not appropriately screened and/or did not consent prior to transfer,
- patients who were not transferred with qualified personnel or equipment,
- transfers that were not approved by a VA physician, or
- pertinent medical records were not sent with patients at the time of transfer.[73]

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

Care Coordination Findings and Recommendations

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

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

Women's Health: Comprehensive Care

Women were estimated to represent approximately 10 percent of the veteran population as of September 30, 2019.[74] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans is anticipated to increase.[75] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[76]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive health care services in all VA medical facilities.[77] VHA also requires that VISNs appoint a lead women veterans program manager (WVPM) to serve as the VISN representative on women veterans' issues and identify gaps through "VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN."[78]

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

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

[74] "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.

[75] "Veteran Population," National Center for Veterans Analysis and Statistics, accessed September 16, 2019, https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf.

[76] Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, Final Report, April 2015.

[77] VHA Directive 1330.01(4), *Health Care Services for Women Veterans,* February 15, 2017, amended January 8, 2021.

[78] VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018.

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

Women's Health Findings and Recommendations

The VISN complied with many of the requirements listed above. However, the OIG identified weaknesses with annual facility site visits and staff education gap assessments.

VHA requires lead WVPMs to complete "yearly site visits at each facility within the VISN and additional site visits as needed."[79] The OIG found that the Charles George, Hampton, and Salem VAMCs had site visits in 2020; however, the remaining four VISN facilities did not (Durham VA and Fayetteville VA Coastal HCSs, and Hunter Holmes McGuire and W.G. (Bill) Hefner VAMCs). Failure to conduct yearly site visits could potentially hinder identification of facility concerns that warrant VISN-level intervention. The Lead WVPM reported only visiting facilities that had pressing issues in 2019 and cited competing priorities (oversight of caregiver support; transition care management; and Lesbian, Gay, Bisexual, and Transgender programs) as the reason for noncompliance.

Recommendation 4

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

VISN concurred.

Target date for completion: September 30, 2022

VISN response: The Network Director evaluated the recommendation and did not determine any additional reasons for noncompliance. The Lead Women Veterans Program Manager completed annual site visits to all facilities in fiscal year 2021. Site visits are tentatively scheduled for fiscal year 2022. The Chief Nursing Officer will monitor and ensure all annual site visits are completed for fiscal year 2022 and reported to the Healthcare Delivery Committee.

[79] VHA Directive 1330.02.

VHA also requires lead WVPMs to conduct "assessments to identify VA staff education gaps related to women's health" and develop or adapt "educational programs, materials, and resources where gaps are identified."[80] The OIG did not find evidence of educational gap assessments. Failure to address education gaps could limit staff's ability to provide key women veterans services. The Lead WVPM reported not officially conducting an education gap analysis because of competing priorities while serving as the Special Populations Program Manager.

Recommendation 5

5. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that the Lead Women Veterans Program Manager completes assessments to identify staff's women's health education gaps and develops or adapts educational programs, materials, or resources where gaps are identified.

VISN concurred.

Target date for completion: August 1, 2022

VISN response: The Network Director evaluated the recommendation and did not determine any additional reasons for noncompliance. The Lead Women Veterans Program Manager created an online education needs assessment. The needs assessment will be sent to staff at each facility within the VISN. Once the needs assessment is complete for each site, the information will be analyzed to determine education gaps. The VISN Lead Women Veterans Program Manager in collaboration with the Facility Women Veterans Program Manager, will develop additional education or make appropriate adaptations to materials and/or resources for the Women's Health Program. The Chief Nursing Officer will monitor for compliance to ensure completion of the educational needs assessment and program updates.

[80] VHA Directive 1330.02.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Healthcare Processes	Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinical vacancies • Oversight inspections • VHA performance data • Observed trends in noncompliance	Five OIG recommendations aimed at reducing vulnerabilities that can lead to patient and staff safety issues or adverse events are attributable to the Network Director and Chief Medical Officer. See details below.
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Vaccine administration	The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 6 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

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

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

Appendix B: VISN 6 Profile

The table below provides general background information for VISN 6.

Table B.1. Profile for VISN 6
(October 1, 2017, through September 30, 2020)

Profile Element	VISN Data FY 2018*	VISN Data FY 2019	VISN Data FY 2020‡
Total medical care budget	$3,871,053,156	$3,901,140,962	$4,845,699,987
Number of:			
• Unique patients	399,591	413,481	415,181
• Outpatient visits	4,867,342	5,095,621	4,794,081
• Unique employees§	15,835	16,617	16,899
Type and number of operating beds:			
• Community living center	676	676	676
• Domiciliary	292	292	283
• Hospital	930	905	908
• Residential rehabilitation	28	28	28
Average daily census:			
• Community living center	406	404	320
• Domiciliary	216	210	107
• Hospital	586	590	456
• Residential rehabilitation	16	13	9

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

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

*****October 1, 2017, through September 30, 2018.*
October 1, 2018, through September 30, 2019.
‡*October 1, 2019, through September 30, 2020.*
§*Unique employees involved in direct medical care (cost center 8200).*

Appendix C: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 6 (October 1, 2019, through September 30, 2020)

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	VHA	69.5
		VISN 6	67.8
		Asheville, NC	85.7
		Durham, NC	64.7
		Fayetteville, NC	58.0
		Hampton, VA	57.8
		Richmond, VA	63.1
		Salem, VA	69.2
		Salisbury, NC	66.7
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	82.5
		VISN 6	81.1
		Asheville, NC	88.9
		Durham, NC	80.5
		Fayetteville, NC	77.4
		Hampton, VA	73.6
		Richmond, VA	82.9
		Salem, VA	86.8
		Salisbury, NC	82.3
Survey of Healthcare Experiences of Patients (outpatient specialty care*): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.8
		VISN 6	83.8
		Asheville, NC	91.0
		Durham, NC	81.5
		Fayetteville, NC	81.5
		Hampton, VA	76.4
		Richmond, VA	85.4
		Salem, VA	88.4
		Salisbury, NC	84.7

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

Appendix D: Office of Inspector General Inspections

Table D.1. Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Clinical Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina, Report No. 16-00576-310, August 1, 2017	March 2017	0	26	–	0
Comprehensive Healthcare Inspection Program Review of the Hampton VA Medical Center, Hampton, Virginia, Report No. 17-01758-104, February 28, 2018	July 2017	0	19	–	0
Comprehensive Healthcare Inspection Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina, Report No. 17-01856-135, March 28, 2018	August 2017	0	10	–	0
Comprehensive Healthcare Inspection Program Review of the Charles George VA Medical Center, Asheville, North Carolina, Report No. 18-01140-312, October 16, 2018	June 2018	0	8	–	0
Comprehensive Healthcare Inspection Program Review of the Durham VA Medical Center, North Carolina, Report No. 18-01146-35, December 19, 2018	July 2018	0	2	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic, Salem, Virginia, Report No. 18-05410-62, January 29, 2019	August 2018	0	5	–	0
Comprehensive Healthcare Inspection Program Review of the Salem VA Medical Center, Virginia, Report No. 18-01161-28, December 17, 2018	August 2018	0	1	–	0
Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina, Report No. 18-05316-234, September 30, 2019	September 2018	0	4	–	0
Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia, Report No. 18-04679-239, September 27, 2019	January 2019	0	21	–	0
Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina, Report No. 19-08256-124, May 19, 2020	July, August, and October 2019	0	12	–	3*

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia, Report No. 19-07600-215, July 29, 2020	September 2019	0	10	–	0
Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina, Report No. 19-09377-192, July 2, 2020	October 2019	0	4	–	1‡
Pharmacy Process Concerns and Improper Staff Communication at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia, Report No. 20-01102-266, September 24, 2020	February 2020	0	5	–	0

Source: Inspection/survey results verified with the QMO on May 10, 2021.

*****As of March 2022, one recommendation issued to the medical center remained open.*

This report also includes one recommendation under the purview of the VHA Under Secretary for Health. For the purpose of comprehensive healthcare inspections, the OIG references only those recommendations under the scope of the VISN and Facilities.

‡*As of November 2021, no recommendations remained open.*

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use 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	Care transition (inpatient)	A higher value is better than a lower 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 (ED)	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
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

Measure	Definition	Desired Direction
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH popu coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	Patient-centered medical home (PCMH) care coordination	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 PC 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
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 7, 2022

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subj: Comprehensive Healthcare Inspection of Veterans Integrated Service Network 6: VA Mid-Atlantic Health Care Network

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

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of Veterans Integrated Service Network 6: VA Mid-Atlantic Health Care Network.

2. I have reviewed and concur with the recommendations and will ensure the actions to correct the findings are completed and sustained as described in the responses. I appreciate the opportunity for this review as a continuing process to improve the care to our Veterans.

(Original signed by:)

Paul S. Crews, MPH, FACHE

OIG Contact and Staff Acknowledgments

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