DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

CHIP REPORT | REPORT #21-00282-111 | MARCH 23, 2022

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Figure 1. *W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina.*

Source: https://www.va.gov/salisbury-health-care/locations/ (*accessed March 15, 2022*).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the W.G. (Bill) Hefner VA Medical Center and related outpatient clinics in 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 inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

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

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

The OIG conducted an unannounced virtual inspection of the W.G. (Bill) Hefner VA Medical Center during the week of May 10, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help this medical center and other Veterans Health Administration (VHA) facilities identify

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

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

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued four recommendations to the Medical Center Director. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the medical center's leadership team consisted of the Medical Center Director, acting Chief of Staff, Associate Director for Patient Care Services/Executive Nurse, acting Associate Medical Center Director, and acting Assistant Medical Center Director. Organizational communications and accountability were managed through a committee reporting structure, with Executive Leadership Board oversight of several working groups. The Director served as the chairperson of the Executive Leadership Board, which had the authority to establish policy, maintain quality care standards, and perform organizational management and strategic planning. Leaders monitored patient safety and care through the Quality Safety & Value Council, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's leaders had worked together for approximately three months. The Associate Director for Patient Care Services/Executive Nurse, who was permanently assigned in August 2016, was the most tenured leader. The Director was assigned in March 2018. The remaining positions were filled by leaders serving in an acting capacity.

The medical center's fiscal year 2020 annual medical care budget increased by almost 23 percent compared to the previous year, and the executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

The OIG reviewed survey results that revealed the acting Chief of Staff had an opportunity to reduce staff feelings of moral distress at work.[2] Selected patient experience survey scores generally reflected similar to or lower care ratings than the VHA averages. In addition, gender-specific survey scores reflected mostly lower scores for both males and females as compared to

[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 moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing." The survey results are not reflective of employee satisfaction with the acting Chief of Staff, acting Assistant Director, or acting Associate Director, who assumed their roles after the survey was administered.

VHA averages. In general, medical center leaders have opportunities to improve patient experiences with inpatient and outpatient care.

The inspection team also reviewed accreditation agency findings and did not identify any substantial organizational risk factors. However, the OIG identified a concern regarding the patient safety program, specifically related to leaders conducting institutional disclosures for all identified sentinel events.[3]

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."[4] The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures affecting the medical and community living centers.[5] In individual interviews, the executive leaders were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for oversight of quality, safety, and value functions and protected peer reviews.[6] However, the OIG identified opportunities for improvement with the Systems Redesign and Improvement Program and Surgical Workgroup.

[3] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[4] "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.)

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

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

Medication Management

The OIG team observed compliance with many elements of expected performance, including staff availability to receive remdesivir shipments, patient criteria for inclusion, and adverse event reporting. However, the OIG found deficiencies with patient or caregiver education.

Care Coordination

The OIG observed compliance with most of the requirements for inter-facility transfers. However, the OIG identified a deficiency with the transmission of patients' advance directives to receiving facilities.

High-Risk Processes

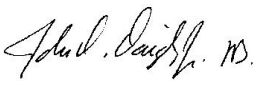
The OIG found the medical center addressed many of the indicators of expected performance, including the development of a disruptive behavior policy, implementation of an employee threat assessment team and a disruptive behavior committee, and completion of the annual Workplace Behavioral Risk Assessment. However, the OIG identified a deficiency with staff training.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued four recommendations for improvement to the Medical Center Director. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for the medical center leader to use the recommendations to help guide improvements in operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Interim Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 60–61, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the W.G. (Bill) Hefner VA Medical Center and related outpatient clinics examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.[1]

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

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

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

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

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

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

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

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

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

5. Medication management (targeting remdesivir use)
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7. Care coordination (spotlighting inter-facility transfers)
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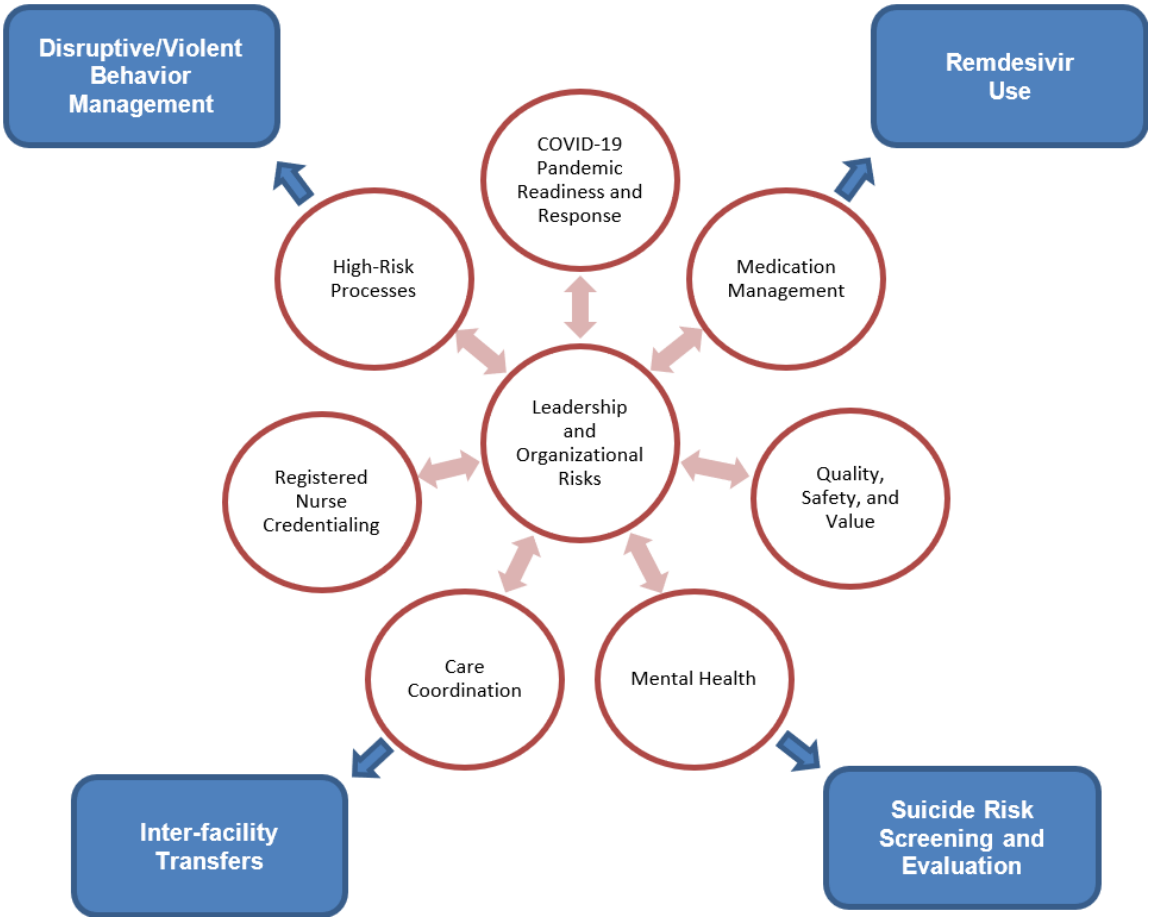


***Figure 2**. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. Source: VA OIG.*

Methodology

The W.G. (Bill) Hefner VA Medical Center also provides care through multiple outpatient clinics in North Carolina. Additional details about the types of care provided by the medical center can be found in appendixes B and C.

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

The inspection examined operations from April 1, 2017, through May 14, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

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

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

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

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect a healthcare system's ability to provide care in the clinical focus areas.[9] To assess this medical center's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the medical center's response
8. VHA performance data (medical center)
9. VHA performance data (community living center (CLC))[10]

Executive Leadership Position Stability and Engagement

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

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

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

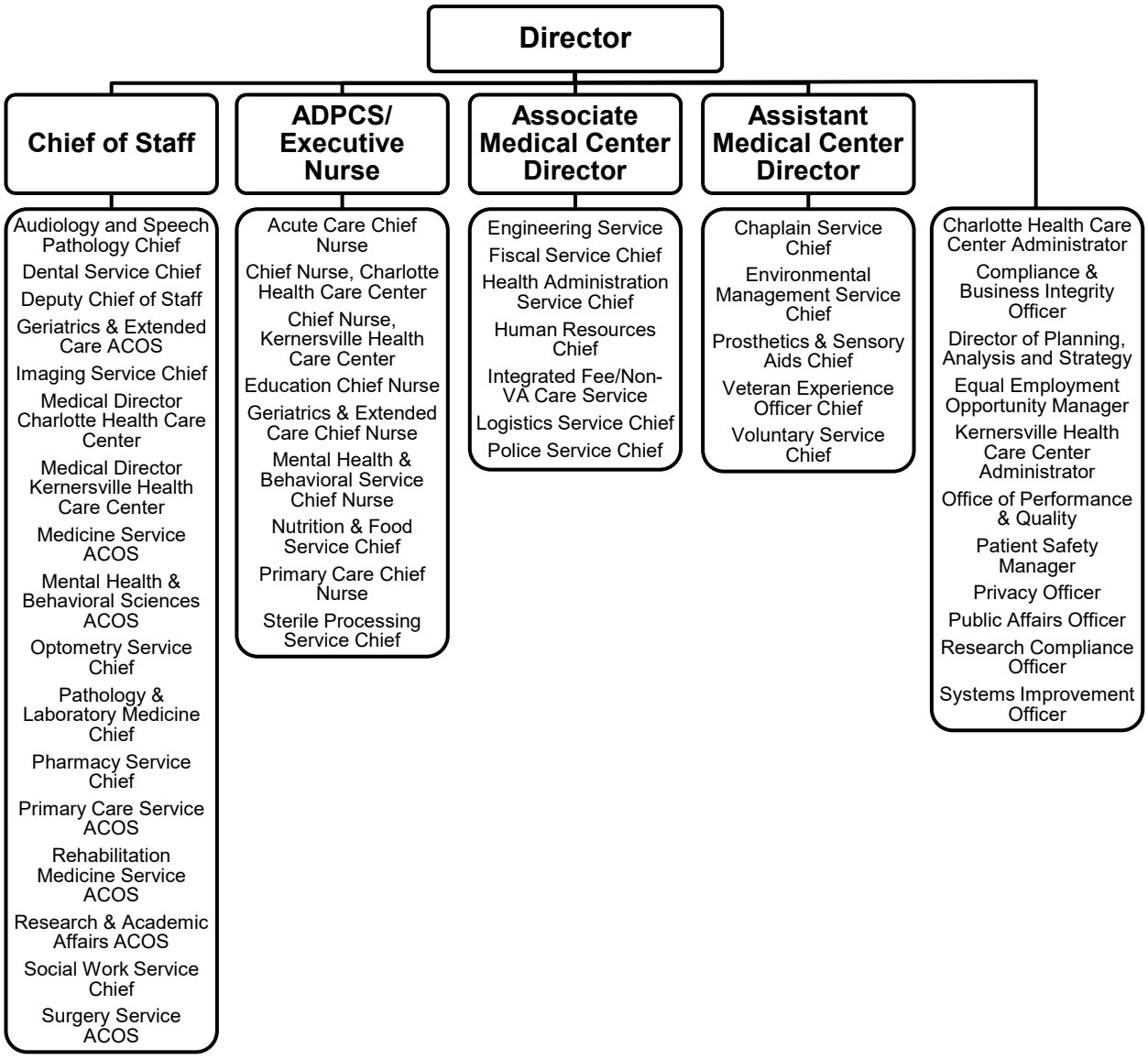


Figure 3. *Medical center organizational chart.*

Source: W.G. (Bill) Hefner VA Medical Center (received May 10, 2021).

ACOS = Associate Chief of Staff.

At the time of the OIG inspection, the executive team had worked together for approximately three months, although the Director and ADPCS/Executive Nurse had served in their roles since 2018 and 2016, respectively. The remaining executive leaders were assigned on an acting basis three to seven months prior to the inspection (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	March 18, 2018
Chief of Staff	October 1, 2020 (acting)
Associate Director for Patient Care Services/Executive Nurse	August 21, 2016
Associate Medical Center Director	October 26, 2020 (acting)
Assistant Medical Center Director	January 31, 2021 (acting)

Source: W.G. (Bill) Hefner VA Medical Center Assistant Chief Human Resources (received May 11, 2021).

The Director served as the chairperson of the Executive Leadership Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board oversaw various working groups such as the Medical Executive Committee and Patient Services Executive, Quality Safety & Value, Administrative Executive, and Organizational Health Councils. These leaders monitored patient safety and care through the Quality Safety & Value Council, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

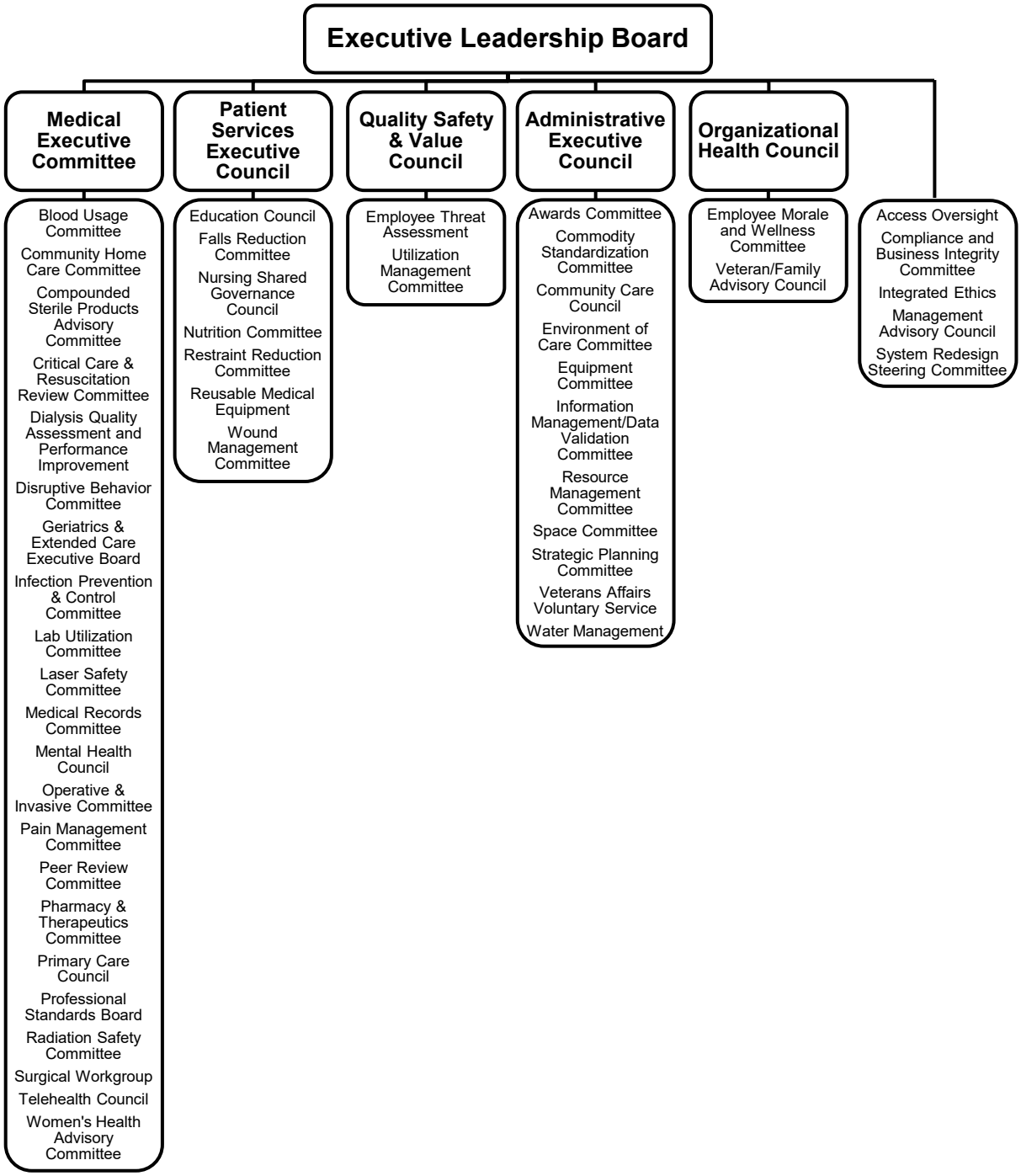


Figure 4. *Medical center committee reporting structure.*

Source: W.G. (Bill) Hefner VA Medical Center (received May 10, 2021).

To help assess the medical center executive leaders' engagement, the OIG interviewed the Director, acting Chief of Staff, ADPCS/Executive Nurse, and acting Associate Director regarding 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 about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The medical center's FY 2020 annual medical care budget of $842,890,502 increased by almost 23 percent compared to the previous year's budget of $687,424,721.[11] When asked about the effect of this change on the medical center's operations, the Director indicated that the additional funds helped replace equipment that was at the end of its lifecycle and expand phone technology to allow for timely communication between nursing staff and patients.

Staffing

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

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[15] The executive leaders confirmed that occupations listed in table 2 remained the top positions for clinical and nonclinical shortages at the time of the OIG inspection. The Director reported challenges with hiring custodial workers because the positions have some preference restrictions.[16] However, to assist with the shortage, the Director explained that the medical center had a contract with a cleaning service for nonclinical areas, leaving clinical areas to be cleaned by VA staff. To help with the psychiatry shortage, the Director stated that a

[11] VHA Support Service Center.

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

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

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

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

[16] 5 C.F.R. § 330.401. "Under 5 U.S.C. 3310, competitive examinations for the positions of custodian, elevator operator, guard, and messenger (referred to in this subpart as *restricted positions*) are restricted to preference eligible as long as a preference eligible is available."

community hospital affiliate worked at the Kernersville community-based outpatient clinic to provide psychiatry care.

The Chief of Staff stated that since the OIG occupational survey, leaders have identified pulmonary medicine and other subspecialty services such as urology, vascular, and thoracic surgery as hiring challenges. In addition, the ADPCS/Executive Nurse reported difficulty hiring RNs for the ED, dialysis, endoscopy, and inpatient mental health units because of the below market VA salaries and the specialized experience needed to work in these areas. Leaders reported using available incentives and seeking new competitive salaries for top candidates to address recruiting and hiring challenges.

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

Top Clinical Staffing Shortage	Top Nonclinical Staffing Shortage
Psychiatry	Custodial worker

Source: VA OIG.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[17] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[18] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[19] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. The OIG found the medical center averages for the selected survey leadership questions were similar to or lower than the VHA averages.[20] For the same survey

[17] "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.)

[18] "AES Survey History."

[19] Ratings are based on responses by employees who reported to or were aligned under the Director, Chief of Staff, ADPCS/Executive Nurse, Associate Director, and Assistant Director. The 2020 All Employee Survey results are not reflective of employee satisfaction with the acting Chief of Staff, acting Assistant Director, or acting Associate Director, who assumed their roles after the survey was administered.

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

questions, the executive leaders' scores were consistently higher than those for VHA and the medical center.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS/ Exec. Nurse Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	73.1	85.0	82.5	85.4	99.4	93.9
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.4	4.6	4.2	4.1	4.8	4.3
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	4.6	4.3	4.1	5.0	4.6
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	4.5	4.4	4.1	5.0	4.7

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 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[21] The medical center averages for the selected survey questions were similar to the VHA averages. Most scores related to the executive leaders were more favorable than those for VHA. However, opportunities appeared to exist for the Chief of Staff to decrease employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believe to be the right thing).

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS/ Exec. Nurse Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.5	4.8	4.6	5.0	4.6
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	4.5	4.3	4.0	4.5	4.0

[21] Ratings are based on responses by employees who reported to or were aligned under the Director, Chief of Staff, ADPCS/Executive Nurse, Associate Director, and Assistant Director.

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS/ Exec. Nurse Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.4	0.5	1.6	1.3	1.0	1.1

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."[22] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[23]

The Director reported implementing strategies related to VA's "Stand Up to Stop Harassment Now!" campaign.[24] These strategies included leaders speaking with new employees at orientation and with veterans at town hall meetings. They shared that harassment and discrimination would not be tolerated at the medical center.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The medical center averages for selected survey questions were slightly lower than the VHA averages, while the executive leaders' averages for the same selected survey questions were consistently higher than VHA averages. Leaders appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.

[22] "Stand Up to Stop Harassment Now!" Department of Veterans Affairs, accessed December 8, 2020, https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/. (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.

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

[24] Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS/ Exec. Nurse Average	Assoc. Director Average	Asst. Director
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.8	4.6	4.3	4.3	4.5	4.8
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.0	4.6	4.2	4.3	4.8	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	3.7	4.3	4.4	4.4	4.9	4.6

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

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the medical center.[25] For this medical center, the overall patient satisfaction survey results generally reflected care ratings similar to VHA averages, although inpatient results indicated that patients were less likely to

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

recommend this hospital to friends and family when compared to VHA patients nationally. Patients appeared generally satisfied with the outpatient care provided.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	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 "Very satisfied" and "Satisfied" responses.	82.5	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 "Very satisfied" and "Satisfied" responses.	84.8	84.7

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[26] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). The results for male respondents were generally similar to or lower than corresponding VHA averages. Despite medical center leaders adding "navigators" to walk women veterans through clinical and preventative care processes and allocating gender-specific outpatient clinic space, most of the scores from female respondents were significantly lower than female VHA patients nationally. Opportunities appeared to exist

[26] "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.

for leaders to address inpatient, patient-centered medical home, and specialty care experiences for all patients.

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

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	68.0	52.9
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	85.5	80.1
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	84.1	70.6

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

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

The medical center averages are based on 367–372 male and 21 or 22 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	43.9	40.9
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	57.0	46.4
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	75.2	68.8

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

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

The medical center averages are based on 343–990 male and 26–55 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	46.3	38.1
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	48.8	43.6
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	75.9	72.5

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

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

The medical center averages are based on 713–1,994 male and 59–130 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[27] Table 10 summarizes the relevant medical center inspections most recently performed by the

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

OIG and The Joint Commission (TJC).[28] At the time of the OIG inspection, medical center leaders had completed action plans for all but one recommendation for improvement issued since the previous Clinical Assessment Program site visit conducted in March 2017. The Quality Manager provided a current action plan to address the one open recommendation, which was from a focused OIG report on airway management processes published in July 2020.[29]

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[30] Additional results included the Long-Term Care Institute's inspection of the medical center's CLC.[31]

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

[29] VA OIG, *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.

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

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

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*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	26	0
OIG (*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	5	1*
TJC Hospital Accreditation	August 2017	37	0
TJC Behavioral Health Care Accreditation		3	0
TJC Home Care Accreditation		3	0

Source: OIG and TJC (inspection/survey results received from the Accreditation Manager on May 11, 2021).

**As of July 28, 2021, the recommendation had been closed.*

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

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

Table 11 lists the reported patient safety events from April 1, 2017 (the prior OIG Clinical Assessment Program site visit), through May 11, 2021.[32]

Table 11. Summary of Selected Organizational Risk Factors (April 1, 2017, through May 11, 2021)

Factor	Number of Occurrences
Sentinel Events	6
Institutional Disclosures	13
Large-Scale Disclosures	0

Source: W.G. (Bill) Hefner VA Medical Center's Patient Safety Manager provided the sentinel events (received May 11, 2021) and the Risk Manager provided the disclosures (received May 10, 2021).

The Director spoke knowledgeably about serious adverse event reporting and specified that all adverse events are discussed after the daily morning report. The Director stated that sentinel events are identified during discussions with the executive leaders, Chief of Quality Management, and Patient Safety Manager. As for institutional disclosures, the Director reported that determinations are made during serious adverse event discussions with the Chief of Staff and Risk Manager, who contacts the family. The Director also informed the OIG that notification of the disclosure is sent to the VISN. The Director described the medical center's process for serious event follow-up, which includes meeting monthly with the Chief of Quality Management and receiving updates from quality management staff during the daily report.

Although the Director was able to speak knowledgeably about the process of reviewing adverse events, including knowledge of action implementation, outcomes monitoring, and action item

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

closure, the OIG identified a concern related to leaders conducting institutional disclosures for adverse events identified as sentinel events. This concern is described in more detail in the findings and recommendations section.

Veterans Health Administration Performance Data for the Medical Center

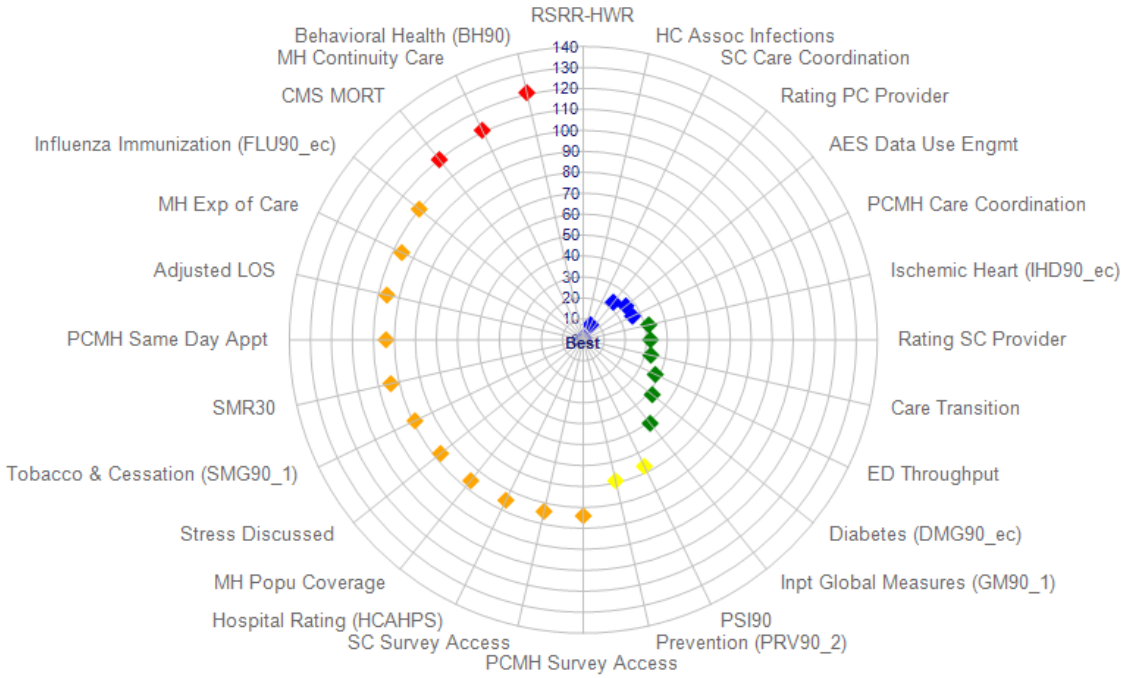
The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[33] Despite noted limitations 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.[34]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the W.G. (Bill) Hefner VA Medical Center's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, health care (HC) associated (assoc) infections, rating (of) primary care (PC) provider, rating (of) specialty care (SC) provider, and care transition). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, stress discussed, adjusted length of stay (LOS), mental health (MH) experience (exp) of care, and mental health (MH) continuity (of) care).[35] The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures.

[33] "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.)

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

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



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

Figure 5. *System quality of care and efficiency metric rankings for FY 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.

Veterans Health Administration Performance Data for the Community Living Center

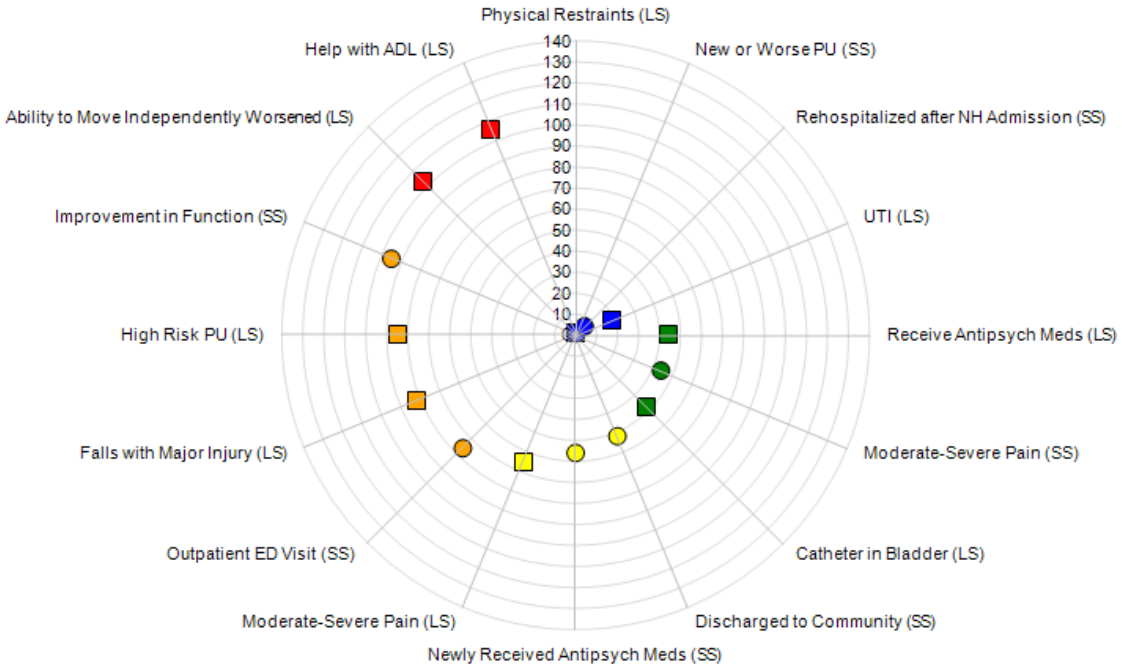
The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[36] The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[37]

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2020. Figure 6 displays the W.G. (Bill) Hefner VA Medical

[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*, July 16, 2021.

[37] 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."

Center's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, physical restraints–long-stay (LS), rehospitalized after nursing home (NH) admission–short-stay (SS), receive antipsychotic (antipsych) meds (LS), and catheter in bladder (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, outpatient ED visit (SS), high risk pressure ulcer (PU) (LS), ability to move independently worsened (LS), and help with activities of daily living (ADL) (LS)).[38] The executive leaders were knowledgeable within their scope of responsibilities about factors contributing to poor performance on specific CLC SAIL measures.



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

Figure 6. *CLC quality measure rankings for FY 2020 quarter 4 (as of September 30, 2020).*
LS = Long-Stay Measure. *SS = Short-Stay Measure.*
Source: VHA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.

Leadership and Organizational Risks Findings and Recommendations

The medical center's executive leadership team had vacancies in three of the five key positions. The Director served as the chairperson of the Executive Leadership Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Director described the positive effect of

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

the increase in the medical center's FY 2020 budget compared to the previous year, and the leaders discussed strategies taken to support providers and alleviate staffing shortages. The leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poorly performing SAIL and CLC SAIL measures and were generally able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

Employee survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated. However, the responses also pointed to an opportunity for the acting Chief of Staff to decrease employee feelings of moral distress at work. Although patient experience survey data implied general satisfaction with the outpatient care provided, scores indicated that patients were less likely to recommend inpatient care to family and friends. Gender-specific scores demonstrated that leaders have opportunities to address both male and female patient experiences in the outpatient setting.

The OIG's review of the system's accreditation findings did not identify any substantial organizational risk factors. Although the Director was able to speak knowledgeably about the process of reviewing adverse events, the OIG identified a concern related to leaders conducting institutional disclosures for sentinel events.

VHA recognizes that the disclosure of harmful events is "consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence," and therefore, requires leaders to conduct an institutional disclosure for sentinel events as defined by TJC.[39] The OIG reviewed the medical center's six reported sentinel events from April 1, 2017, through May 11, 2021, and did not find evidence that leaders conducted an institutional disclosure for four events. The failure to conduct an institutional disclosure conflicts with VA's core values and can reduce patients' trust in the organization. Quality management staff reported conducting a root cause analysis or clinical disclosure instead of an institutional disclosure when they believed the patients were not harmed or that no long-term effects would result from the adverse events.[40]

[39] VHA Directive 1004.08. VHA defines an institutional disclosure as "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

[40] VHA Directive 1004.08. Clinical disclosure is "a process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the course of care."

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures leaders conduct institutional disclosures for all sentinel events.

Medical center concurred.

Target date for completion: August 8, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance in conducting institutional disclosures for all sentinel events. All sentinel events have resulted in institutional disclosures beginning May 14, 2021. The Risk Manager will review and track sentinel events to ensure leaders conduct institutional disclosures on all sentinel events. The percentage of compliance will be reported to the Quality Safety & Value Council monthly for oversight. Compliance will be monitored to ensure 90 percent or greater compliance for a minimum of six consecutive months.

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.[41] 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.[42]

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."[43] "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."[44]

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

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

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

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

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[41] "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.

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

[43] 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 "[p]rovision 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."

[44] 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.[45] 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.[46] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[47]

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

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

The OIG reviewers also assessed the medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[48] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[49] The OIG team examined various requirements related to systems redesign and improvement:

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

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

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[50] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[51] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[52] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[53]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[54]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[55] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities;

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

[51] VHA Directive 1190.

[52] VHA Directive 1190.

[53] VHA Directive 1190.

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

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[56] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (RN)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[57]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, the National Surgery Office report, and other relevant information.[58]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions and protected peer reviews. However, the OIG identified opportunities for improvement with the Systems Redesign and Improvement Program and Surgical Workgroup.

VHA requires the systems redesign and improvement coordinator to participate on the VISN Systems Redesign Review Advisory Group to review program data and information.[59] The OIG reviewed VISN Systems Redesign Review Advisory Group meeting minutes from June 2020 through April 2021 and found that the Systems Redesign Manager (this medical center's systems redesign and improvement coordinator) did not participate in 4 of 9 meetings (44 percent).[60] The lack of participation could hinder leaders' oversight and result in missed opportunities to identify improvement needs. The Systems Redesign Manager, who started in January 2021, was unable to provide a reason for the prior Systems Redesign Manager's lack of attendance at the four VISN meetings.

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

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

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

[59] VHA Directive 1026.01.

[60] The VISN Systems Redesign Review Advisory Group did not meet in August or September 2020.

Recommendation 2

2. The Medical Center Director determines the reasons for noncompliance and ensures the Systems Redesign Manager participates on the Veterans Integrated Service Network Systems Redesign Review Advisory Group.

Medical center concurred.

Target date for completion: August 2, 2022

Medical center response: The Medical Center Director determined position vacancy was the reason for noncompliance of the Systems Redesign Manager participating on the VISN Systems Redesign Review Advisory Group. The Systems Redesign Manager position was vacant from May 2020 to January 19, 2021. The current Systems Redesign Manager or designee has attended the VISN Systems Redesign Review Advisory Group beginning February 2021. The Systems Redesign Manager completed a Delegation Memorandum to state the Systems Redesign and Improvement Specialist will act as the Systems Redesign Manager representative during the Systems Redesign Manager's absence and has the authority to fulfill the duties of signatory approval on correspondence, attend meetings as the Systems Redesign Manager representative, and complete any other Systems Redesign Manager tasks. Attendance will be recorded in the VISN Systems Redesign Review Advisory Group minutes. The Accreditation Manager will monitor and track the Systems Redesign Manager's participation in the VISN Systems Redesign Review Advisory Group and report the attendance compliance to Quality Safety & Value Council quarterly. Compliance will be monitored to ensure 90 percent or greater compliance for a minimum of six consecutive months.

VHA requires medical facilities with surgery programs to have a surgical work group that meets at least monthly and includes the Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[61] The OIG reviewed Surgical Workgroup meeting minutes from May 2020 through April 2021 and found that the Chief of Staff did not attend 8 of 12 meetings (67 percent). The lack of core member attendance could result in the review and analysis of surgery program data without the perspectives of key staff. The Chief of Staff reported that attendance at COVID-19-related meetings contributed to inconsistent Surgical Workgroup meeting attendance.

Recommendation 3

3. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that required members regularly attend Surgical Workgroup meetings.

[61] VHA Directive 1102.01(1).

Medical center concurred.

Target date for completion: August 2, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance that required members regularly attend Surgical Workgroup meetings. The Surgical Quality Nurse will monitor and track attendance of required members by review of the Surgical Workgroup meeting minutes, which will be reported to Medical Executive Committee on a quarterly basis for oversight. Compliance of all required members attendance at Surgical Workgroup will be monitored until 90 percent or greater compliance is met for six consecutive months for each member.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[62] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[63]

VA requires all RNs to hold at least one active, unencumbered license.[64] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[65] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[66] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[67]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 48 RNs hired from July 1, 2020, through April 11, 2021. The OIG determined whether

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

The OIG also reviewed credentialing files for 30 of the 48 RNs to determine whether medical center staff completed primary source verification prior to the appointment.

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

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

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

[65] 38 U.S.C. § 7402.

[66] VHA Directive 2012-030.

[67] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[68] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[69]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[70] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[71]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[72] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[73]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of 24 patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

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

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

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

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

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

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

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

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
  - Potential pregnancy
  - Kidney assessment (estimated glomerular filtration rate)[74]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[75]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the medical center addressed many of the indicators of expected performance, including staff availability to receive remdesivir shipments, patient criteria for inclusion, and adverse event reporting. However, the OIG found deficiencies with patient or caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, inform patients and/or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients and/or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[76] For the 24 patients who received remdesivir, the OIG determined that, prior to administering the medication, healthcare providers did not

- provide 96 percent of patients or caregivers the *Fact Sheet for Patients and Parents/Caregivers*,
- inform 79 percent of patients or caregivers that remdesivir was not an FDA-approved medication,
- notify 96 percent of patients or caregivers of the option to refuse remdesivir,

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

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

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

- advise 63 percent of patients or caregivers of the risks and benefits of receiving remdesivir, and
- inform 63 percent of patients or caregivers of alternatives to remdesivir.

This could have resulted in patients or caregivers lacking the information needed to make a fully informed decision to receive medication. The Chief of Medicine reported believing that the medicine and infectious disease teams provided the appropriate education but did not document it using the specific language in the fact sheet. The Chief of Medicine also reported that staffing challenges and reassignments due to the COVID-19 pandemic caused a delay in the development of a standardized template to capture the required documentation.

Given the FDA's approval of remdesivir for use in adult patients requiring hospitalization for the treatment of COVID-19, the OIG made no recommendations related to Emergency Use Authorization requirements.[77]

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

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[78] 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.[79] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[80]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in EDs or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[81] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the ED or urgent care center.[82] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

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

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

- the electronic health records of 49 randomly selected patients who were seen in the ED or urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[83]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients."[84] Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[85]

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

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

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 48 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with most of the requirements for inter-facility transfers. However, the OIG identified a deficiency with the transmission of patients' advance directives to receiving facilities.

VHA requires that "all pertinent medical records available, including an active patient medication list and any medications given to the patient prior to transfer [be sent] with the

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

[84] VHA Directive 1094.

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

patient, including documentation of the patient's advance directive made prior to transfer, if any."[86] The OIG found that for the 14 patients who had an advance directive, staff did not send a copy with the patient to the receiving facility. As a result, there was no assurance that receiving facility staff could determine patient preferences regarding future healthcare decisions in the event the patient no longer had decision-making capability.[87] The Nurse Manager, Patient Flow Department reported that ED providers ask the patient if they have an advance directive instead of reviewing the patient's electronic health record for the document. The Chief, ED added that the providers need better training on the importance of looking for the advance directive in the record instead of relying on the patient's response. Due to the low number of patients identified for this review element, the OIG made no recommendation.

[86] VHA Directive 1094.

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

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[88] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[89] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[90]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[91]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[92]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[93]

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

[89] VHA Directive 2012-026.

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

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

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

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

VHA requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[94] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[95] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG found the medical center addressed many of the indicators of expected performance, including the development of a disruptive behavior policy, implementation of an employee threat assessment team and a disruptive behavior committee, and completion of the annual Workplace Behavioral Risk Assessment. However, the OIG identified a deficiency with staff training.

VHA requires that staff are assigned prevention and management of disruptive behavior part 1 training when hired and "additional levels of PMDB [prevention and management of disruptive behavior] training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment."[96] The OIG found that 9 of 30 selected staff (30 percent) did not complete the required training. This could result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Chief of Staff reported that the Director and VISN leaders decided to pause the prevention and management of disruptive behavior face-to-face training, effective March 23, 2020, due to potential employee exposure to COVID-19. However, executive leaders approved resuming the training, in alignment with Centers for Disease Control and Prevention recommendations, effective April 21, 2021.

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

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

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

Recommendation 4

4. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that staff complete all required prevention and management of disruptive behavior training.[97]

Medical center concurred.

Target date for completion: January 3, 2023

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance with staff completion of prevention and management of disruptive behavior training. The Prevention and Management of Disruptive Behavior (PMDB) Coordinator completed a comprehensive review to ensure all staff are assigned to the appropriate level(s) of PMDB training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment. The PMDB Coordinator continues to monitor staff compliance of all required prevention and management of disruptive behavior training completion. PMDB Level 2 classes were resumed in June 2021 and the PMDB Coordinator increased the number of PMDB Level 2 classes being offered. On January 7, 2022, Salisbury VA HCS reinstated its moratorium on face-to-face classes due to COVID-19 case increases. Beginning February 7, 2022, the PMDB Coordinator will offer a virtual alternative PMDB Level 2 low risk training in response to the COVID 19 pandemic. PMDB Level 2 moderate/high risk and Level 3 have been suspended during the COVID-19 pandemic per facility operations. The executive leadership team and Chief of Hospital Education/Workforce Development are conducting monthly meetings to discuss restarting the Level 2 moderate/high risk and Level 3 PMDB training. Compliance of all required prevention and management of disruptive behavior trainings will be monitored until 90 percent or greater compliance has been met for six consecutive months. The PMDB Coordinator will run monthly training reports from the VHA training database. The compliance data for all PMDB levels will be reported monthly to Quality Safety & Value Council.

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

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed review of eight clinical and administrative areas and provided four recommendations on issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this medical center. However, the OIG's findings illuminate areas of concern and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines four OIG recommendations aimed at improving vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Medical Center Director. The intent is for the leader to use the recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

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

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• None	• The Systems Redesign Manager participates on the VISN Systems Redesign Review Advisory Group. • Required members regularly attend Surgical Workgroup meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None

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

Appendix B: Medical Center Profile

The table below provides general background information for this high complexity (1b) affiliated medical center reporting to VISN 6.[1]

Table B.1. Profile for W.G. (Bill) Hefner VA Medical Center (659) (October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019	Medical Center Data FY 2020‡
Total medical care budget	$730,166,166	$687,424,721	$842,890,502
Number of:			
• Unique patients	90,010	94,095	87,690
• Outpatient visits	943,683	994,882	924,113
• Unique employees§	2,653	2,755	2,899
Type and number of operating beds:			
• Community living center	124	124	124
• Domiciliary	56	56	56
• Medicine	31	33	30
• Mental health	40	40	46
• Residential rehabilitation	8	8	8
• Surgery	13	7	7

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

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019	Medical Center Data FY 2020‡
Average daily census:			
• Community living center	87	102	89
• Domiciliary	43	37	21
• Medicine	24	24	21
• Mental health	30	33	28
• Residential rehabilitation	7	6	4
• Surgery	3	2	2

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

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

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

October 1, 2018, through September 30, 2019.

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

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Kernersville, NC	659BY	39,004	22,552	Allergy Cardiology Cardio thoracic Dermatology Endocrinology Eye Gastroenterology General surgery Hematology/ Oncology Infectious Disease	EKG Laboratory & Pathology Nuclear medicine Radiology	Dental Nutrition Pharmacy Prosthetics Social work Weight management

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Kernersville, NC (continued)	659BY			Nephrology Neurology Orthopedics Otolaryngology Plastic Podiatry Pulmonary/ Respiratory Disease Rehabilitation physician Rheumatology Spinal cord injury Urology Vascular		
Charlotte, NC	659BZ	43,453	24,408	Allergy Cardiology Dermatology Eye Endocrinology Gastroenterology General surgery Gynecology Hematology/ Oncology Infectious Disease Nephrology Neurology	Laboratory & Pathology Nuclear medicine Radiology	Dental Nutrition Pharmacy Prosthetics Weight management

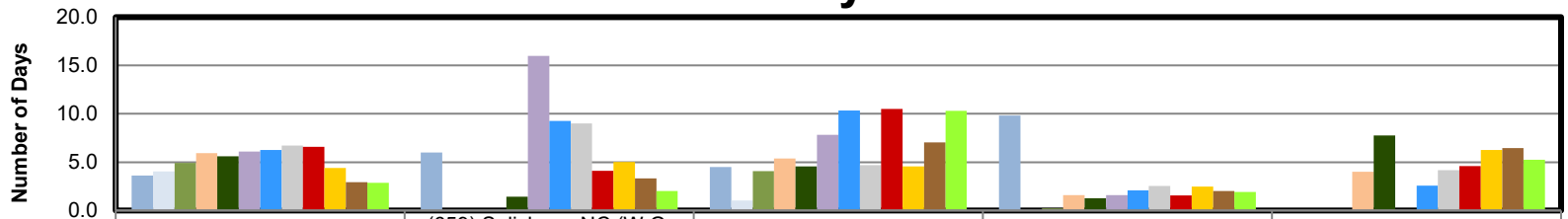
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Charlotte, NC (continued)	659BZ			Pulmonary/ Respiratory Disease Orthopedics Otolaryngology Plastic Podiatry Rehabilitation physician Rheumatology Spinal cord injury Urology		
Charlotte, NC	659GA	8,343	3,460	Dermatology Eye	Laboratory & Pathology Radiology	Pharmacy

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

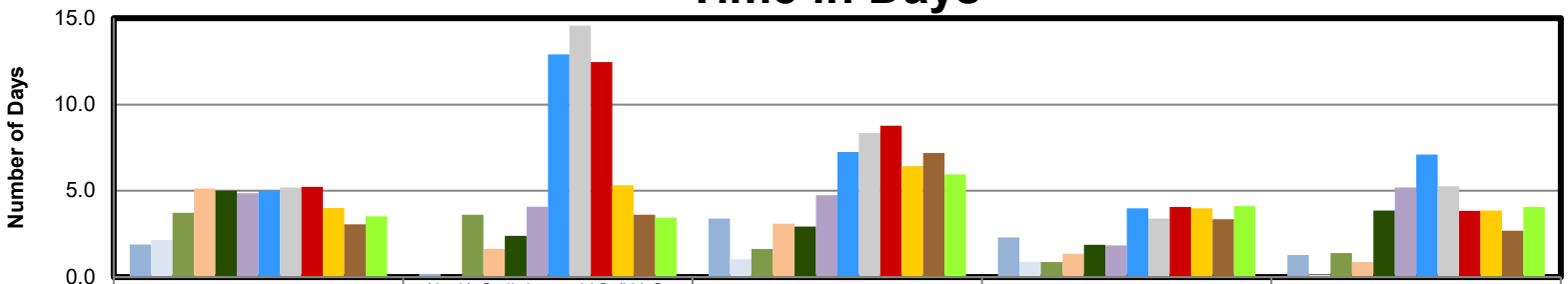


	All VHA	(659) Salisbury, NC (W.G. (Bill) Hefner Salisbury)	(659BY) Kernersville, NC	(659BZ) Charlotte, NC	(659GA) Charlotte, NC
APR-FY20	3.6	6.0	4.5	9.8	n/a
MAY-FY20	4.0	0.0	1.0	0.0	n/a
JUN-FY20	4.9	0.0	4.1	0.2	0.0
JUL-FY20	5.9	0.0	5.4	1.6	4.0
AUG-FY20	5.6	1.4	4.6	1.3	7.8
SEP-FY20	6.1	16.0	7.8	1.6	0.0
OCT-FY21	6.3	9.3	10.3	2.1	2.6
NOV-FY21	6.7	9.0	4.7	2.5	4.2
DEC-FY21	6.6	4.1	10.5	1.6	4.6
JAN-FY21	4.4	5.0	4.6	2.5	6.3
FEB-FY21	2.9	3.3	7.0	2.0	6.4
MAR-FY21	2.9	2.0	10.3	1.9	5.3

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019. (This is an internal website not publicly accessible.)

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

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



	All VHA	(659) Salisbury, NC (W.G. (Bill) Hefner Salisbury)	(659BY) Kernersville, NC	(659BZ) Charlotte, NC	(659GA) Charlotte, NC
APR-FY20	1.9	0.2	3.4	2.3	1.3
MAY-FY20	2.1	0.0	1.0	0.9	0.1
JUN-FY20	3.7	3.6	1.6	0.9	1.4
JUL-FY20	5.1	1.6	3.1	1.4	0.9
AUG-FY20	5.0	2.4	2.9	1.9	3.9
SEP-FY20	4.9	4.1	4.7	1.8	5.2
OCT-FY21	5.0	12.9	7.3	4.0	7.1
NOV-FY21	5.2	14.6	8.3	3.4	5.3
DEC-FY21	5.2	12.5	8.8	4.1	3.8
JAN-FY21	4.0	5.3	6.4	4.0	3.9
FEB-FY21	3.1	3.6	7.2	3.4	2.7
MAR-FY21	3.5	3.4	6.0	4.1	4.1

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019. (This is an internal website not publicly accessible.)

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

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

Appendix 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
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
Diabetes (DMG90_ec)	HEDIS outpatient performance measure composite for diabetes care	A higher value is better than a lower value
ED throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Healthcare associated infections	A lower value is better than a higher value
Hospital rating (HCAHPS)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Inpt global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value

Measure	Definition	Desired Direction
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	A higher value is better than a lower value
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH popu coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	Care coordination (PCMH)	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating 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

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

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 2, 2022

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

Subj: Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

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

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

1. We appreciate the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina.

2. I have reviewed the recommendations and concur with the responses and submitted actions provided by our team at the W.G. (Bill) Hefner VA Medical Center to ensure we continue to deliver excellent care to our Veterans.

(Original signed by:)

Lindsey J. Crain for Paul S. Crews, MPH, FACHE
VISN Director

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 1, 2022

From: Interim Director, W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina (659/00)

Subj: Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina.

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 appreciated the opportunity for this review as a continuing process to improve the care to our Veterans.

(Original signed by:)

J. Ronald Johnson, MHA, FACHE
Interim Director

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