



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the VA
Maryland Health Care
System in Baltimore



MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

FOR MORE
VA OIG REPORTS
CLICK HERE



**Report suspected wrongdoing in VA programs and operations
to the VA OIG Hotline:**

www.va.gov/oig/hotline

1-800-488-8244



Figure 1. VA Maryland Health Care System in Baltimore.

Source: <https://www.maryland.va.gov> (accessed November 11, 2021).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CI	confidence interval
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 VA Maryland Health Care System, which includes three divisions—the Baltimore VA Medical Center, Loch Raven VA Medical Center, and Perry Point VA Medical Center—and multiple outpatient clinics in Maryland. 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 response¹
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 VA Maryland Health Care System during the week of August 9, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors’ ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system’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 healthcare system and other Veterans Health Administration (VHA)

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](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 (coronavirus disease) is an infectious disease caused by the “severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).”

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

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued eight recommendations to the System Director, Chief of Staff, and Associate Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the healthcare system's leadership team consisted of the System Director, interim Deputy Director, Chief of Staff, Associate Director for Patient Care Services, interim Chief Quality Officer, interim Associate Director for Operations, and interim Assistant Director. The healthcare system's leaders had worked together in their current roles for nearly three months, except for the interim Deputy Director, who was assigned one day prior to the inspection. The System Director had served in the role since December 2020, and the Chief of Staff and Associate Director for Patient Care Services had been in their positions for more than five years.

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

The healthcare system's fiscal year 2020 annual medical care budget had increased 8 percent compared to the previous year's budget.² The executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Selected employee survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated. Patient experience survey data implied general satisfaction with the outpatient care provided; however, both male and female respondents indicated a lower likelihood of recommending the hospital to friends and family compared to VHA patients nationally. Outpatient survey results indicated that male respondents were more satisfied with their primary care, whereas female respondents were more satisfied with their specialty care.

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

² VHA Support Service Center.

VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.”³ The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures. Leaders also demonstrated an understanding of Community Living Center SAIL measures.⁴

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.⁵ In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.⁶

Quality, Safety, and Value

The healthcare system complied with requirements for a committee responsible for quality, safety, and value oversight functions; the Systems Redesign and Improvement Program; and Surgical Work Group processes. However, the OIG identified areas of improvement for protected peer reviews.⁷

Medication Management

The OIG team observed compliance with many elements of expected performance, including the availability of staff to receive remdesivir shipments, confirmation of COVID-19 infection and inclusion criteria, completion of required testing prior to remdesivir administration, and reporting

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

⁴ 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.

⁵ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.”

⁶ VA OIG, *Comprehensive Healthcare Inspection of Facilities’ COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

⁷ 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.

of adverse events. However, the OIG found a deficiency with the provision of patient or caregiver education.

Care Coordination

Generally, the healthcare system met expectations for an inter-facility transfer policy. However, the OIG identified deficiencies with monitoring and evaluation of inter-facility transfers and completion of all elements of the required VA *Inter-Facility Transfer Form* or a facility equivalent note, transmission of active medication lists and advance directives, and communication between nurses at sending and receiving facilities.⁸

High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior. 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 eight recommendations for improvement to the System Director, Chief of Staff, and Associate Director for Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for system leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

⁸ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

VA Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 66–67, and the responses within the body of the report for the full text of the leaders’ comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations	ii
Report Overview	iii
Inspection Results	iv
Purpose and Scope	1
Methodology	3
Results and Recommendations	4
Leadership and Organizational Risks.....	4
COVID-19 Pandemic Readiness and Response.....	27
Quality, Safety, and Value	29
Recommendation 1	32
Recommendation 2	32
Recommendation 3	33
Registered Nurse Credentialing	35
Medication Management: Remdesivir Use in VHA	37
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	40
Care Coordination: Inter-facility Transfers.....	42
Recommendation 4	43
Recommendation 5	44

Recommendation 6	45
Recommendation 7	45
High-Risk Processes: Management of Disruptive and Violent Behavior	47
Recommendation 8	49
Report Conclusion.....	50
Appendix A: Comprehensive Healthcare Inspection Program Recommendations	51
Appendix B: Healthcare System Profile	54
Appendix C: VA Outpatient Clinic Profiles	56
Appendix D: Patient Aligned Care Team Compass Metrics	59
Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions	61
Appendix F: Community Living Center (CLC) Strategic Analytics for Improvement and Learning (SAIL) Measure Definitions.....	64
Appendix G: VISN Director Comments.....	66
Appendix H: System Director Comments	67
OIG Contact and Staff Acknowledgments	68
Report Distribution	69



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 VA Maryland Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so that informed decisions can be made to improve care.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 response⁵
3. Quality, safety, and value
4. Registered nurse credentialing

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](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 (coronavirus disease) is an infectious disease caused by the “severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).”

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

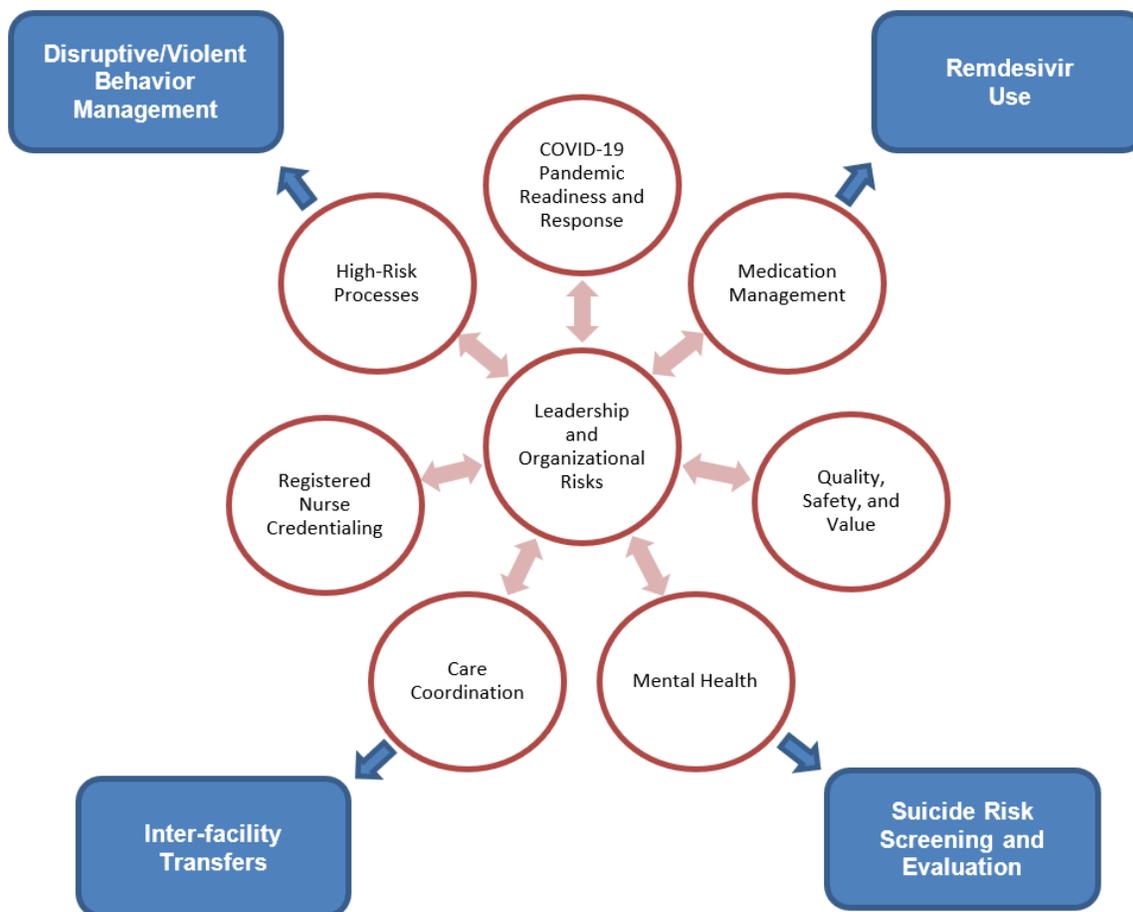


Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.
Source: VA OIG.

Methodology

The VA Maryland Health Care System includes the Baltimore VA Medical Center, the Loch Raven VA Medical Center, the Perry Point VA Medical Center, and multiple outpatient clinics in Maryland. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from March 16, 2019, through August 13, 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 reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.⁸

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁹ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

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 CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in August 2021.

⁸ VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

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

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this healthcare system's reported organizational structure. At the time of the OIG's virtual inspection, the healthcare system had a leadership team consisting of the System Director, interim Deputy Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), interim Chief Quality Officer, interim Associate Director for Operations, and interim Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

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

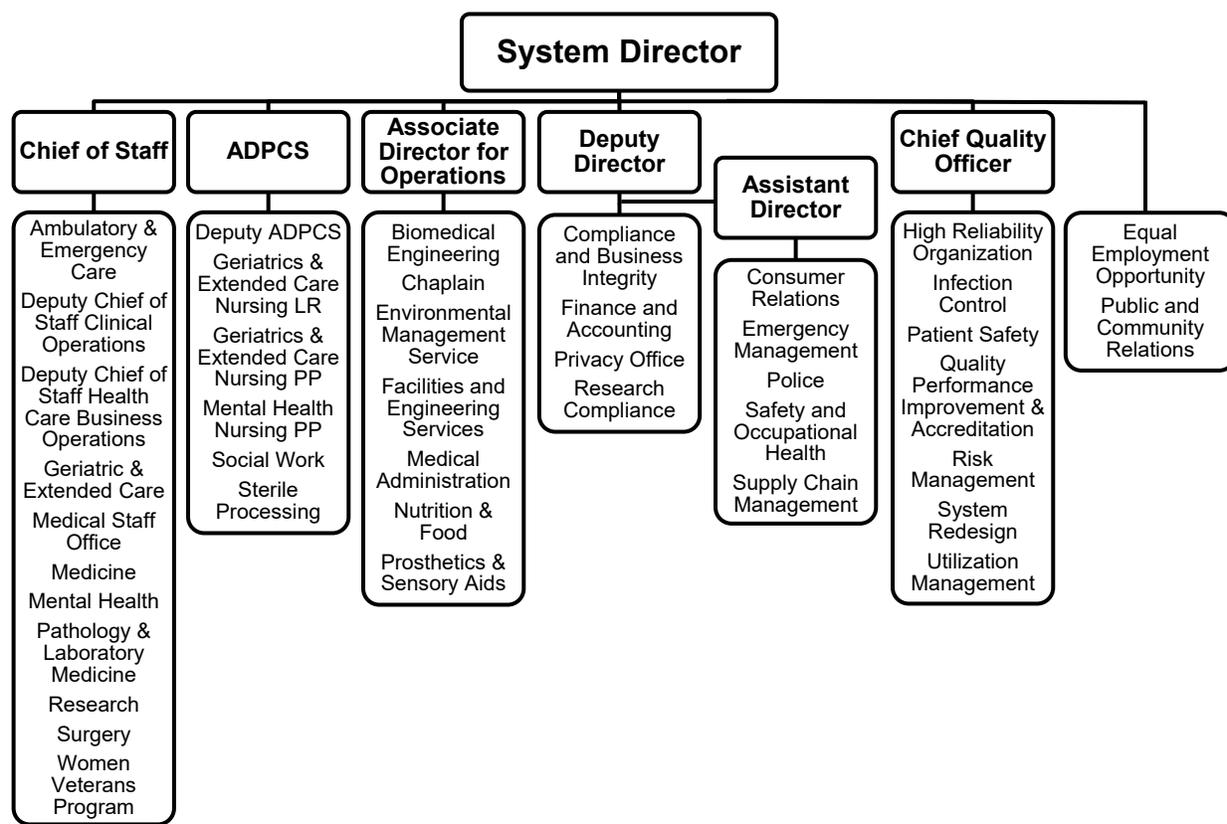


Figure 3. Healthcare system organizational chart.

LR = Loch Raven PP = Perry Point

Source: VA Maryland Health Care System (received August 9, 2021).

At the time of the OIG inspection, the executive team had worked together in their current roles for nearly three months, except for the interim Deputy Director, who was assigned the day before the inspection. The System Director had served in the role since December 2020 and the Chief of Staff and ADPCS had been in their positions for more than five years (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
System Director	December 20, 2020
Deputy Director	August 8, 2021 (interim)
Chief of Staff	March 6, 2016
Associate Director for Patient Care Services	May 12, 2012
Associate Director for Operations	May 24, 2021 (interim)
Chief Quality Officer	May 27, 2021 (interim)
Assistant Director	March 29, 2021 (interim)

Source: VA Maryland Health Care System Assistant Human Resource Officer/Senior Strategic Business Partner and interim Chief Quality Officer/ADPCS (originally received August 11, 2021; updated September 16, 2021).

The System 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 executive councils of the medical staff, administrative staff, patient care services, resources management, quality, and environment of care. These leaders monitored patient safety and care through the Executive Quality Council, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

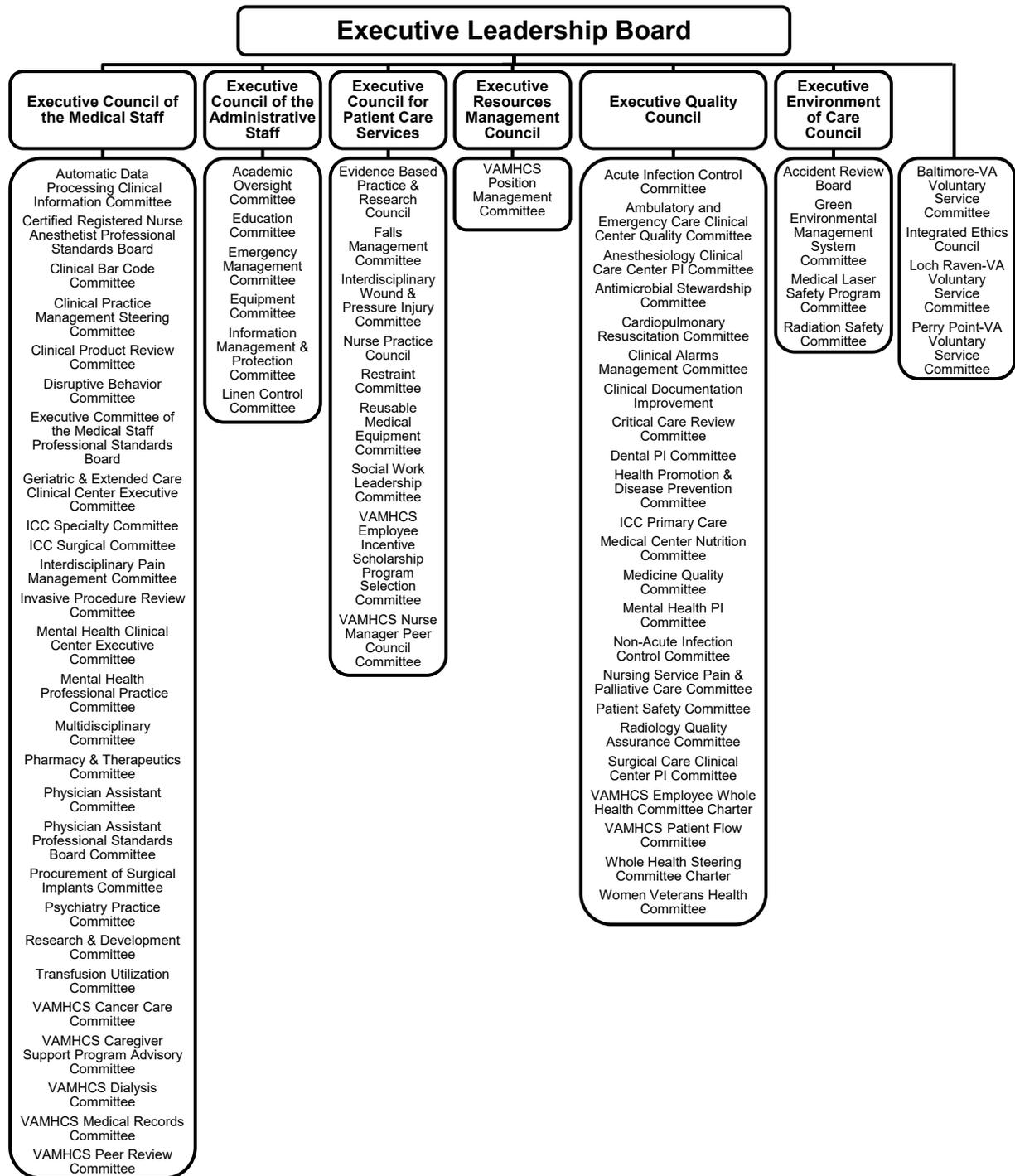


Figure 4. Healthcare system committee reporting structure.

ICC = Integrated Clinical Community

PI = Performance Improvement

VAMHCS = VA Maryland Health Care System

Source: VA Maryland Health Care System (received August 9, 2021).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the System Director, Chief of Staff, ADPCS, and interim Associate Director for Operations regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of \$743,655,430 increased by 8 percent compared to the previous year's budget of \$688,982,538.¹² According to the System Director, the increased funds provided allocations for COVID-19-related costs, including overtime pay, retention incentives for nursing personnel, and additional furniture and sneeze guards to create barriers for social distancing. The remaining funds were used to implement special salary rates for police officers and laboratory technicians.

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.¹³ 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.¹⁴ In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.¹⁵

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*.¹⁶ The executive leaders confirmed that the occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection, except for primary care physicians and purchasing agents. The System Director also reported staffing shortages in engineer and biomedical engineer positions. The Chief of Staff added that despite recently hiring 12 new police officers, shortages in police and pharmacy technician positions

¹² VHA Support Service Center.

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

¹⁴ 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.

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

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

continued. Leaders reportedly addressed shortages for key positions through special salary rates, recruitment from academic affiliates, education debt reduction programs, and sign-on bonuses.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Primary Care	1. Medical Support Assistance
2. Psychiatry	2. Police
3. Psychology	3. Purchasing
4. Pharmacy Technician	4. Human Resources Management
5. Medical Instrument Technician	5. Inventory Management

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 healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey from October 1, 2019, through September 30, 2020.¹⁹ Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. The OIG found that healthcare system averages for the selected survey questions were similar to VHA averages.²⁰ Scores for the executive team were generally higher than those for VHA and the healthcare system.²¹

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 report to or are aligned under the System Director, Chief of Staff, ADPCS, Associate Director for Operations, and Associate Director for Finance. The survey results reflect the prior organizational structure.

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.

²¹ The 2020 All Employee Survey Scores are not reflective of employee satisfaction with the current System Director and interim Associate Director of Operations, who assumed the roles after the survey was administered.

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

Questions/ Survey Items	Scoring	VHA Average	Health- care System Average	System Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Operations Average	Assoc. Director Finance Average
All Employee Survey: <i>Servant Leader Index Composite.*</i>	0–100 where higher scores are more favorable	73.8	73.7	83.6	91.7	–†	81.1	84.6
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.5	3.4	4.1	4.4	3.6	4.0	4.2
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.6	4.1	4.4	3.6	4.0	4.2
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.7	3.7	4.4	4.6	3.8	4.1	4.4

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

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

†All Employee Survey results did not include a Servant Leader Index Composite score for the ADPCS.

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA’s All Employee Survey.²² The healthcare system averages for the selected survey questions were similar to the VHA averages. Results for the executive team were generally more favorable than those for VHA and the healthcare system.²³

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

Questions/ Survey Items	Scoring	VHA Average	Health- care System Average	System Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Operations Average	Assoc. Director Finance Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.5	4.8	4.2	3.8	4.1
All Employee Survey: <i>Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.7	3.9	4.4	—*	4.0	4.3

²² Ratings are based on responses by employees who report to or are aligned under the System Director, Chief of Staff, ADPCS, Associate Director for Operations, and Associate Director for Finance.

²³ The 2020 All Employee Survey Scores are not reflective of employee satisfaction with the current System Director and interim Associate Director of Operations, who assumed the roles after the survey was administered.

Questions/ Survey Items	Scoring	VHA Average	Health- care System Average	System Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Operations Average	Assoc. Director Finance Average
All Employee Survey: <i>In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?</i>	0 (Never)– 6 (Every Day)	1.4	1.3	0.3	0.9	–†	1.3	0.8

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

*All Employee Survey results did not include a score for the ADPCS related to doing what is right even if employees feel it puts them at risk.

†All Employee Survey results did not include a score for the ADPCS related to moral distress at work.

VHA leaders have articulated that the agency “is committed to a harassment-free health care environment.”²⁴ 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.²⁵

The System Director reported implementing strategies from the campaign to strengthen organizational communications and demonstrate a commitment to a culture of safety. Healthcare system leaders held an all-employee town hall and allowed staff to ask questions about harassment. The System Director also reported developing a Microsoft SharePoint (web-based document sharing) site for employees and supervisors to post and access documents pertaining to harassment.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA’s All Employee Survey responses. The healthcare system and executive leadership team averages for the selected survey questions were similar to or better than VHA averages.²⁶ Leaders

²⁴ “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.

²⁵ “Stand Up to Stop Harassment Now!”

²⁶ The 2020 All Employee Survey Scores are not reflective of employee satisfaction with the current System Director and interim Associate Director of Operations, who assumed the roles after the survey was administered.

appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.

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

Questions/ Survey Items	Scoring	VHA Average	Health- care System Average	System Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Operations Average	Assoc. Director Finance Average
All Employee Survey: <i>People treat each other with respect in my workgroup.</i>	1 (Strongly Disagree) -5 (Strongly Agree)	3.9	3.8	4.4	4.6	4.0	4.2	4.4
All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i>	1 (Strongly Disagree) -5 (Strongly Agree)	4.0	4.0	4.4	4.7	4.0	4.3	4.2
All Employee Survey: <i>Members in my workgroup are able to bring up problems and tough issues.</i>	1 (Strongly Disagree) -5 (Strongly Agree)	3.8	3.8	4.5	4.5	3.6	4.2	4.4

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

Patient Experience

To assess patient experiences with the healthcare system, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through September 30, 2020. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and benchmark 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 healthcare system.²⁷ For this system, the overall patient survey results revealed general satisfaction in outpatient settings, while opportunities exist for leaders to improve inpatient experiences. The ADPCS reported that leaders addressed this issue by conducting rounds through units, making follow-up calls, and meeting with family members to ensure that all questions had been addressed. The ADPCS suggested that the system’s Baltimore location is inherently unappealing to patients who may not feel safe in the neighborhood.

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

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	69.5	58.3
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	82.5	82.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	84.8	84.6

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

²⁷ Ratings are based on responses by patients who received care at this healthcare system.

by 2048.²⁸ 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). For inpatient care, results indicated that female patients perceived being treated with courtesy and respect by doctors; however, leaders had opportunities to improve male patients' perceptions of the courtesy and respect they received from doctors and nurses. Patients, regardless of gender, were less likely to recommend the hospital to their friends and family.

The Chief of Staff reported establishing patient aligned care teams that included a nurse, clerk, and social worker, as well as embedding a mental health professional in primary care to increase teamwork. Additionally, the Chief of Staff discussed efforts to improve telephone response times through an automated call distributor system, enhance cleanliness throughout the hospital, and increase nursing staff responsiveness. System leaders reportedly obtained portable computers to allow patients to remotely communicate with nurses rather than waiting for them put on the appropriate personal protective equipment before entering rooms. The Chief of Staff also stated that leaders acquired the *Yacker Tracker*, which provides a visual signal of excessive noise levels.²⁹

For outpatient care, male patients appeared generally satisfied with their primary care experiences but less pleased with their specialty care. Conversely, results indicated that female patients were satisfied with their specialty care but less so with primary care. The ADPCS explained that generational differences between male and female patients may be a factor in the responses provided, with females generally representing a younger demographic who may be better equipped to express their specialty care needs and understand treatment plans.

²⁸ "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.

²⁹ "Attention Getters Inc. (AGI): Uses of the Yacker Tracker," accessed December 13, 2021, <https://yackertracker.com/uses/>.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>Would you recommend this hospital to your friends and family?</i>	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	58.5	55.5
<i>During this hospital stay, how often did doctors treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	82.9	93.0
<i>During this hospital stay, how often did nurses treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	80.8	83.5

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

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

†The healthcare system averages are based on 409–414 male and 27 or 28 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	53.3	37.0
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	60.1	44.4
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	76.1	68.0

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

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

†The healthcare system averages are based on 642–1,807 male and 69–153 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	47.0	74.6
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	52.3	64.4
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	72.8	77.0

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

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

The healthcare system averages are based on 423–1,140 male and 46–119 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.³⁰ Table 10

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

summarizes the relevant system inspections most recently performed by the OIG and The Joint Commission (TJC).³¹

At the time of the OIG inspection, healthcare system leaders had completed action plans for all but four CHIP recommendations for improvement issued since the previous site visit conducted in March 2019. As of September 14, 2021, only one recommendation, pertaining to damaged furniture repairs or removal, remained open. The interim Chief Quality Officer reported assigning the Performance Improvement Specialist to work with Environmental Management and Interior Design to monitor the furniture repair/removal requests and ensure timely responses. Additionally, the system had two open recommendations from two OIG focused inspections that were published on November 26, 2019, and June 11, 2020, respectively.³² As of September 14, 2021, system leaders were actively working toward compliance for the one open recommendation issued in the June 2020 report, with follow-up scheduled for October 2021.

At the time of the virtual inspection, the OIG team also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.³³ Additional results included the Long Term Care Institute's inspection of the system's CLCs.³⁴

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

³² VA OIG, *Alleged Wrongful Death and Deficiencies in Documentation of a Patient's Do Not Attempt Resuscitation Status at the Baltimore VA Medical Center*, Report No. 19-05916-24, November 26, 2019; VA OIG, *Coordination of Care and Employee Satisfaction Concerns at the Community Living Center, Loch Raven VA Medical Center, in Baltimore, Maryland*, Report No. 19-08857-171, June 11, 2020.

³³ 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.

³⁴ "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 Surveys

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Concerns Related to an Inpatient's Response to Oxycodone and Facility Actions at the Baltimore VA Medical Center, Maryland, Report No. 18-05731-176, July 29, 2019</i>)	October 2018	6	0
OIG (<i>Alleged Wrongful Death and Deficiencies in Documentation of a Patient's Do Not Attempt Resuscitation Status at the Baltimore VA Medical Center, Maryland, Report No. 19-05916-24, November 26, 2019</i>)	January and February 2019	4	1*
OIG (<i>Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, Maryland, Report No. 19-00016-61, January 9, 2020</i>)	March 2019	23	1†
OIG (<i>Coordination of Care and Employee Satisfaction Concerns at the Community Living Center, Loch Raven VA Medical Center, in Baltimore, Maryland, Report No. 19-08857-171, June 11, 2020</i>)	September 2019	5	1‡
TJC Behavioral Health for Cause	October 2019	1	0
TJC Behavioral Health Care and Human Services (Opioid Treatment Program)	November 2020	2	0
TJC Hospital Accreditation	March 2021	57	0
TJC Behavioral Health Care and Human Services Accreditation		5	0
TJC Home Care Accreditation		5	0

Source: OIG and TJC (inspection/survey results received from the interim Chief Quality Officer/ADPCS on August 10, 2021, and updated information on September 14, 2021, from the Accreditation Specialist).

*As of March 2022, no recommendations remained open.

†As of March 2022, no recommendations remained open.

‡As of November 2021, no recommendations remained open.

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

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

Table 11 lists the reported patient safety events from March 16, 2019 (the prior OIG CHIP site visit), through August 17, 2021.³⁵

Table 11. Summary of Selected Organizational Risk Factors (March 16, 2019, through August 17, 2021)

Factor	Number of Occurrences
Sentinel Events	45
Institutional Disclosures	36
Large-Scale Disclosures	0

Source: VA Maryland Health Care System’s interim Chief Quality Officer/ADPCS, Patient Safety Manager, and Risk Management Program Manager (initially received August 18–20, 2021; updated September 21, 2021).

The System Director spoke knowledgeably about serious adverse event reporting and indicated that adverse events were discussed at morning conferences, but staff also reported events by telephone after hours. The System Director described making institutional disclosure determinations in collaboration with the Chief of Staff and Deputy Chief of Staff and supporting

³⁵ 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 VA Maryland Health Care System 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.”

decisions to disclose events when recommended. Of the 45 sentinel events identified by system staff, only 25 met the TJC definition of a sentinel event and required an institutional disclosure.³⁶ The interim Chief Quality Officer, ADPCS, and System Director reported electing to perform institutional disclosures on some adverse events even though they did not meet the definition of a sentinel event. The System Director also stated that leaders complete an average of 12 to 14 root cause analyses per year and during the six months prior to the virtual inspection, they completed more than the minimum requirement. The System Director specified that the Chief of Staff managed peer review issues, including the use of an algorithm to help determine the appropriate approach.³⁷ Reportedly, the system’s process for serious event follow-up included committees tracking administrative and clinical issues through root cause analyses, peer reviews, and other activities and documenting the results in meeting minutes.

Veterans Health Administration Performance Data for the Healthcare System

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.”³⁸ Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.³⁹

Figure 5 illustrates the healthcare system’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. It shows the VA Maryland Health Care System’s performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (acute care 30-day standardized mortality ratio (SMR30), mental health (MH) population coverage, and all cause hospital-wide readmission rate (RSRR-HWR)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, healthcare (HC) associated (assoc) infections, ED throughput, and MH continuity

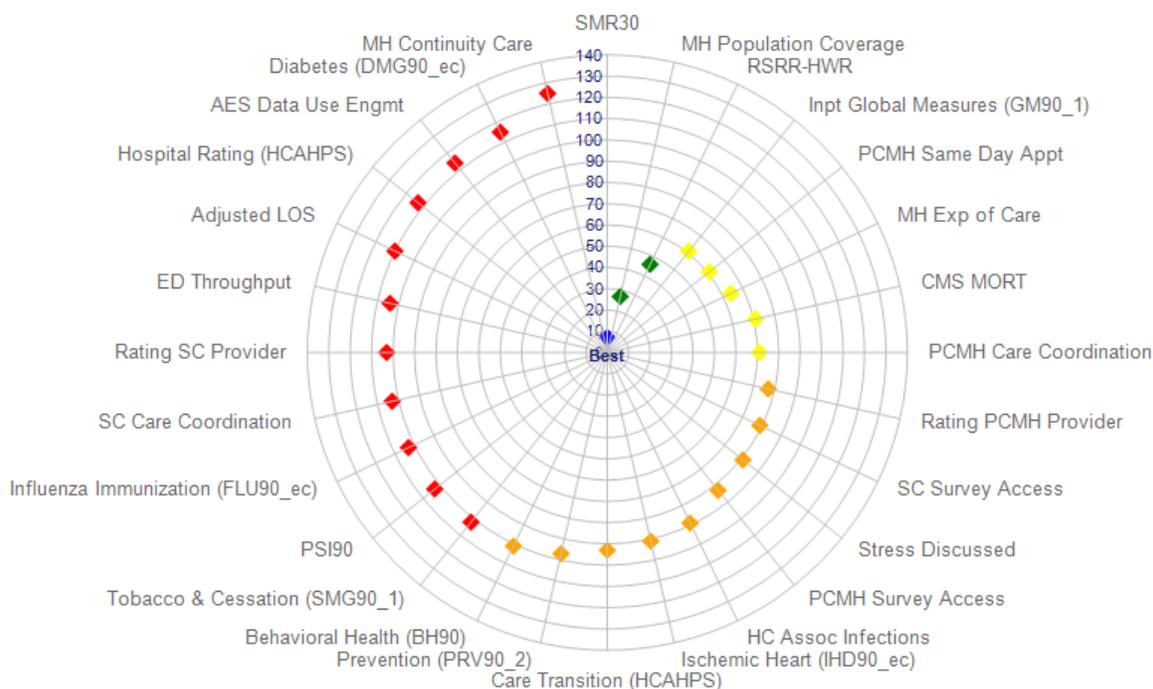
³⁶ VHA Directive 1004.08. “Disclosure is warranted for harmful or potentially-harmful adverse events...that are sentinel events as defined by The Joint Commission.”

³⁷ 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. 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.”

³⁸ “Strategic Analytics for Improvement and Learning (SAIL) Value Model,” VHA Support Service Center, accessed on March 6, 2020, <https://vssc.med.va.gov>. (This is an internal website not publicly accessible.)

³⁹ “Strategic Analytics for Improvement and Learning (SAIL) Value Model.”

[of] care).⁴⁰ The executive leaders were very knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures.



Marker color: Blue - 1st quintile; Green - 2nd quintile; Yellow - 3rd quintile; 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 Centers

The CLC SAIL Value Model is a tool to “summarize and compare performance of CLCs in the VA.”⁴¹ The model leverages much of the same data used in the Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare* and provides a single resource “to review

⁴⁰ For information on the acronyms in the SAIL metrics, please see appendix E.

⁴¹ Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC). A tool to examine Quality Using Internal VA Benchmarks*, July 16, 2021.

quality measures and health inspection results.”⁴² Leaders demonstrated an understanding of CLC SAIL measures.

Figures 6 and 7 illustrate the system’s CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. Figure 6 displays the Loch Raven VA Medical Center’s CLC metrics with high performance (blue data points) in the first quintile (for example, moderate-severe pain–long-stay (LS), physical restraints (LS), and new or worse pressure ulcer (PU)–short-stay (SS)). The Loch Raven CLC has no metrics in the second quintile (green data points). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, urinary tract infection (UTI) (LS), falls with major injury (LS), and outpatient ED visit (SS)).⁴³

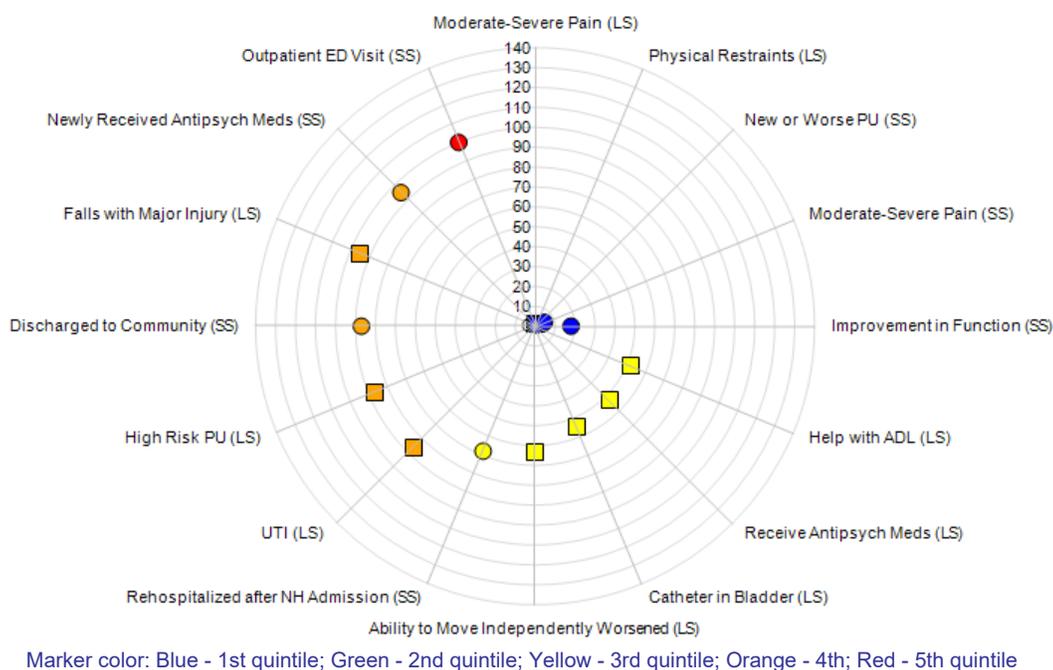


Figure 6. Loch Raven CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).

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

Source: VHA Support Service Center.

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

⁴² Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks*. “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its Nursing Home Compare public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

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

Figure 7 displays the Perry Point VA Medical Center’s CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, catheter in bladder (LS), outpatient ED visit (SS), and UTI (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, moderate-severe pain (SS), discharged to community (SS), and rehospitized after nursing home (NH) admission (SS)).

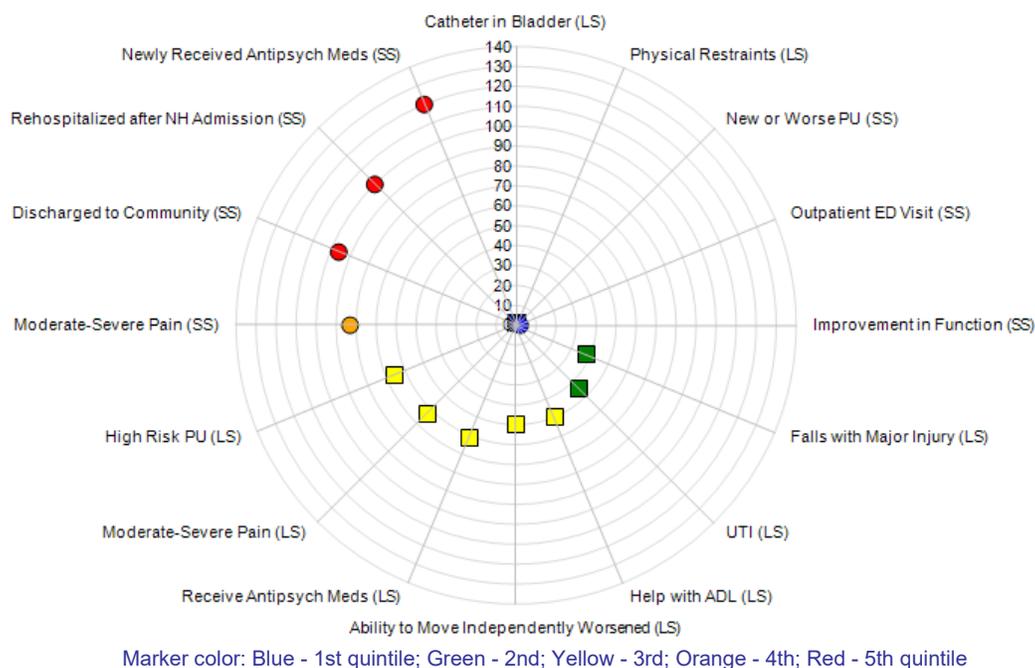


Figure 7. Perry Point CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG inspection, the system’s executive leadership team had four vacancies in the seven key positions, and one of the permanent positions (system director) had been filled for less than one year. The System 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 healthcare system’s FY 2020 annual medical care budget had increased 8 percent compared to the previous year’s budget, and the executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Selected employee satisfaction survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated.

Patient experience survey data implied general satisfaction with the outpatient care provided; however, both male and female respondents indicated a lower likelihood of recommending the hospital to friends and family compared to VHA respondents nationally. Outpatient survey results indicated that male respondents were more satisfied with their primary care, but female respondents were more satisfied with their specialty care.

The OIG's review of the healthcare system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. Leaders were very knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL and CLC SAIL measures. In individual interviews, the executive leadership team members seemed well-informed about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the “alarming levels of spread and severity” of COVID-19, the World Health Organization declared a pandemic.⁴⁴ VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.⁴⁵

During this time, VA continued providing care to veterans and engaged its fourth mission, the “provision of hospital care and medical services during certain disasters and emergencies” to persons “who otherwise do not have VA eligibility for such care and services.”⁴⁶ “In effect, VHA facilities provide a safety net for the nation’s hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans.”⁴⁷

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

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

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

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

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

⁴⁶ 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). VA’s missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA’s fourth mission, the “[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.”

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

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.⁴⁸

⁴⁸ VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

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.⁴⁹ 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.⁵⁰ 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.”⁵¹

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

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

The OIG reviewers also assessed the healthcare system’s processes for its Systems Redesign and Improvement Program, which supports “VHA’s transformation journey to become a High Reliability Organization.”⁵² 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.”⁵³ 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

⁴⁹ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

⁵⁰ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

⁵¹ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

⁵² VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

⁵³ VHA Directive 1026.01.

Next, the OIG assessed the healthcare system’s processes for conducting protected peer reviews of clinical care.⁵⁴ 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.”⁵⁵ Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.⁵⁶ 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 unit⁵⁷
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews⁵⁸
- Quarterly review of the Peer Review Committee’s summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the healthcare system’s surgical program. The VHA National Surgery Office provides oversight for surgical programs and “promotes systems and practices that enhance high quality, safe, and timely surgical care.”⁵⁹ The National Surgery Office’s principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include “(1) Operational oversight of surgical services and quality improvement activities; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select

⁵⁴ 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.”

⁵⁵ VHA Directive 1190.

⁵⁶ VHA Directive 1190.

⁵⁷ VHA Directive 1190.

⁵⁸ VHA Directive 1190. A peer review is assigned a Level 3 when “most experienced and competent clinicians would have managed the case differently.”

⁵⁹ “NSO Reporting, Resources, & Tools,” VA Surgical Quality Improvement Program, accessed November 21, 2020, <https://dvagov.sharepoint.com/sites/VHANSOVASQIP/SitePages/Default.aspx>. (This is an internal VA website not publicly accessible.)

specialty programs.”⁶⁰ The healthcare system’s performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (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 events⁶¹

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.⁶²

Quality, Safety, and Value Findings and Recommendations

The healthcare system complied with requirements for a committee responsible for QSV oversight functions, the Systems Redesign and Improvement Program, and Surgical Work Group processes. However, the OIG identified areas of improvement for protected peer reviews.

VHA requires peer reviewers to use at least one of nine aspects of care to evaluate peer review findings.⁶³ The OIG found that 2 of 19 peer reviews (11 percent) lacked evidence that reviewers used at least one aspect of care to support the preliminary peer review level. This may affect the ability of the Peer Review Committee to determine if appropriate care was provided. The interim Chief Quality Officer and Risk Management Program Nurse Manager cited human error and a lack of oversight as the reasons for noncompliance.

⁶⁰ “NSO Reporting, Resources, & Tools.”

⁶¹ VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

⁶² For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

⁶³ VHA Directive 1190.

Recommendation 1

1. The Chief of Staff evaluates and determines additional reasons for noncompliance and ensures that peer reviewers use at least one of the nine aspects of care for evaluations.

Healthcare system concurred.

Target date for completion: September 30, 2022

Healthcare system response: The Chief of Staff, in collaboration with the Risk Management Team, evaluated and determined reasons for noncompliance. As a result, a new Peer Review worksheet was created and implemented effective October 1, 2021. The new document includes the approved nine aspects of care, per VHA Directive 1190, dated November 2018. All Peer Review worksheets noting only eight aspects of care were removed from circulation by the Risk Management Team, effective August 12, 2021. The Risk Management Team audited the new process for compliance by reviewing each Peer Review worksheet on initiation and upon completion of each completed review received. All members of the Risk Management Team are responsible to ensure the documents are reviewed and reconciled in real-time with the Risk Management Nurse Manager who maintained overall responsibility for accuracy and completeness. The Peer Review Program statuses are discussed weekly with the Chief Quality Officer and reported to the Executive Council of the Medical Staff, quarterly.

VHA requires the Peer Review Committee to complete a final review of peer review cases and recommend “non-punitive, non-disciplinary actions to improve the quality of healthcare delivered.”⁶⁴ The OIG found that the Peer Review Committee did not recommend improvement actions for any of the nine Level 3 peer reviews, which likely prevented improvements in the providers’ patient care practices. The Risk Management Program Nurse Manager stated that rather than the Peer Review Committee making recommendations, the service chiefs provided action plans for the Peer Review Committee to approve, and they believed this met the requirement.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that the Peer Review Committee recommends improvement actions for Level 3 peer reviews.

⁶⁴ VHA Directive 1190.

Healthcare system concurred.

Target date for completion: September 30, 2022

Healthcare system response: The Chief of Staff, in collaboration with the Risk Management Team, evaluated and determined reasons for noncompliance. For every final level two or three assigned, a non-punitive action for improvement was discussed and approved by the Peer Review Committee. A new process was implemented on August 12, 2021, where the Peer Review Committee recommends improvement actions for each final level two or three. These actions are assigned and discussed, approved, and documented in the official meeting minutes. All members of the Risk Management Team are responsible to ensure the new process is completed in real-time, and the Risk Management Nurse Manager maintains overall responsibility for accuracy and completeness. The Peer Review Program statuses are discussed weekly with the Chief Quality Officer and reported to the Executive Council of the Medical Staff, quarterly.

VHA requires that final peer reviews are completed within 120 calendar days from the determination that a peer review is needed, or a written extension request is approved by the System Director.⁶⁵ From July 2020 through June 2021, the OIG found that the Peer Review Committee did not complete 6 of 20 peer reviews (30 percent) within the expected time frame or request an extension. This likely prevented timely improvements in patient care throughout the healthcare system. The Risk Management Program Nurse Manager stated that the peer review cases were stored in an unidentified electronic folder for unknown reasons, and therefore, not tracked by staff. This is a repeat finding previously identified in the 2019 comprehensive healthcare inspection.⁶⁶

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Peer Review Committee completes final peer reviews within 120 calendar days from the date it is determined a peer review is required, or the System Director approves any necessary extensions in writing.

⁶⁵ VHA Directive 1190.

⁶⁶ VA OIG, *Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, Maryland*, Report No. 19-00016-61, January 9, 2020.

Healthcare system concurred.

Target date for completion: September 30, 2022

Healthcare system response: The Chief of Staff, in collaboration with the Risk Management Team, evaluated and determined reasons for noncompliance. The previously implemented process for reconciliation of the Peer Review Tracker and electronic folders against the VACO [Veterans Affairs Central Office] spreadsheet was sustained effective October 1, 2021. At day 110, each open case in the peer review process was reviewed and evaluated for a need of a Medical Center Director (MCD) extension memo. An official written request was submitted and obtained for any cases not scheduled to close by the 120th day. All approved and signed MCD extension memos are maintained by the Risk Management Staff in the assigned electronic case folder. This sustained process has proven instrumental in the timely tracking of initiated peer reviews to completion and/or receipt of a signed MCD extension memo prior to the 120th day of the peer review process. All members of the Risk Management Team are responsible to monitor set timelines, per VHA Directive 1190, dated November 2018 in real-time with the Risk Management Nurse Manager who maintained overall responsibility for accuracy and completeness. The Peer Review Program status is discussed weekly with the Chief Quality Officer and reported to the Executive Council of the Medical Staff, quarterly.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of “professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate.”⁶⁷ 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.”⁶⁸

VA requires all RNs to hold at least one active, unencumbered license.⁶⁹ 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.⁷⁰ 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.⁷¹ 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.⁷²

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 57 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 the credentialing files for 30 of the 57 RNs to determine whether healthcare system staff completed primary source verification prior to appointment.

⁶⁷ VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (This directive was rescinded and replaced with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. The two documents contain similar language regarding credentialing procedures.)

⁶⁸ VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

⁶⁹ VHA Directive 2012-030, replaced by VHA Directive 1100.20. 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.”

⁷⁰ 38 U.S.C. § 7402.

⁷¹ VHA Directive 2012-030, replaced by VHA Directive 1100.20.

⁷² VHA Directive 2012-030, replaced by VHA Directive 1100.20.

Registered Nurse Credentialing Findings and Recommendations

The healthcare system 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-19.⁷³ 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.⁷⁴

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.⁷⁵ 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.⁷⁶

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."⁷⁷ The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.⁷⁸

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 16 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

⁷³ 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.

⁷⁴ Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

⁷⁵ Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*, May 8, 2020.

⁷⁶ 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*.

⁷⁷ 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.

⁷⁸ 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)⁷⁹
 - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)⁸⁰
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the healthcare system addressed many of the indicators of expected performance, including availability of staff to receive medication shipments, confirmation of COVID-19 infection and inclusion criteria, completion of required testing prior to medication administration, and reporting of adverse events to the FDA. However, the OIG found deficiencies with the provision of patient or caregiver education.

Under the Emergency Use Authorization, the VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, inform patients or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.⁸¹

Of the 16 patients who received remdesivir, the OIG determined that healthcare providers did not inform 13 percent of patients or caregivers of the option to refuse remdesivir. This could have resulted in the patient or caregiver lacking the information needed to make a fully informed decision to receive the medication. The Antimicrobial Stewardship Director stated that early in the pandemic, providers were still learning the documentation requirements for counseling and did not capture all elements in the electronic health record. The Clinical Pharmacy Specialist

⁷⁹ “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.”

⁸⁰ “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.

⁸¹ VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

added that frequent guidance provided by multiple agencies, including the VA and FDA, further confused the providers about the requirements.

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.⁸²

⁸² Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19," Updated December 8, 2020.

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 2019.⁸³ 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 2018.⁸⁴ However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.⁸⁵

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.⁸⁶ 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.⁸⁷ The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

⁸³ “Suicide Prevention: Facts About Suicide,” Centers for Disease Control and Prevention, accessed October 8, 2021, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

⁸⁴ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.

⁸⁵ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.

⁸⁶ 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.

⁸⁷ 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

The healthcare system generally complied with the requirements listed above. The OIG made no recommendations.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.⁸⁸

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.”⁸⁹ 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.⁹⁰

The healthcare system was assessed for its adherence to various requirements:

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

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 44 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG found general compliance for maintaining a current inter-facility transfer policy. However, the OIG identified deficiencies with monitoring and evaluation of inter-facility transfers, completion of all elements of the required VA *Inter-Facility Transfer Form* or a facility equivalent note, transmission of the patient’s active medication list and advance directive, and communication between nurses at sending and receiving facilities.

⁸⁸ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁸⁹ VHA Directive 1094.

⁹⁰ VHA Directive 1094. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients’ informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

VHA requires that the Chief of Staff and ADPCS ensure that “all transfers are monitored and evaluated as part of VHA’s Quality Management Program.”⁹¹ The OIG did not find evidence that staff monitored and evaluated patient transfers conducted from July 1, 2020, through June 30, 2021. Failure to monitor patient transfers could prevent the identification of system-level deficiencies that put patients at risk. The Deputy Chief of Staff, Healthcare and Business Operations reported being unaware of the requirement.

Recommendation 4

4. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that staff monitor and evaluate all transfers as part of VHA’s Quality Management Program.

Healthcare system concurred.

Target date for completion: December 2022

Healthcare system response: The Chief of Staff (COS) and Associate Director for Patient Care Services (ADPCS) evaluated and determined no additional reasons for noncompliance. The COS and ADPCS will continue to ensure a monthly chart review of 30 charts or 100% if less than 30 transfers for compliance with Directive 1094 to ensure 90% compliance sustained over 6 months or two quarters. Deputy Chief of Staff/ designee will present the data quarterly to the Executive Quality Council (EQC) quarterly.

VHA requires providers to complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note prior to the patient transfer.⁹² The OIG estimated that providers did not complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note for 93 percent of patient transfers (95% CI: 84.8 and 100 percent), which is statistically significantly above the 10 percent deficiency benchmark. This failure could have resulted in unsafe patient transfers. The Lead Physician, Urgent Care Clinic reported being unaware that the transfer form or equivalent note was required.

VHA policy states that transferring providers must record specific elements in the transfer form, such as documentation of informed consent, patients’ stability for transfer, and identification of receiving providers.⁹³ The OIG estimated that transferring providers did not document informed consent for 27 percent (95% CI: 14.9 and 40.9 percent), patients’ stability for transfer for 91 percent (95% CI: 81.5 and 97.8 percent), and identification of receiving providers for 68 percent (95% CI: 54.4 and 81.8 percent) of patient transfers, which are all statistically significantly above the 10 percent deficiency benchmark. The lack of consistent processes could result in the

⁹¹ VHA Directive 1094.

⁹² VHA Directive 1094.

⁹³ VHA Directive 1094.

unsafe transfer of patients to other healthcare facilities. The Chief, Emergency Medicine stated that providers obtained informed consent but did not scan the form into the electronic health record. Further, the Deputy Chief of Staff, Healthcare and Business Operations reported believing that providers' documentation of the patient's stability in the ED or urgent care clinic, even when unrelated to stability for transfer, met the requirement. Additionally, the Lead Physician, Urgent Care Clinic explained that providers identified the receiving providers but did not document their names in the electronic health record.

Recommendation 5

5. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure that transferring providers complete all elements of the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record.

Healthcare system concurred.

Target date for completion: December 2022

Healthcare system response: The COS and ADPCS evaluated and determined no additional reasons for noncompliance. The COS and ADPCS will continue to ensure a monthly chart review of 30 charts or 100% if less than 30 transfers for compliance with Directive 1094 (Use of VA Inter-Facility Transfer Form) to ensure 90% compliance sustained over 6 months or two quarters. Deputy Chief of Staff/ designee will present the data quarterly to the Executive Quality Council (EQC) quarterly.

VHA requires transferring providers to send "all pertinent medical records available, including an active patient medication list and...documentation of the patient's advance directive" to the receiving facility during inter-facility transfers.⁹⁴ The OIG estimated that transferring providers did not send the active medication list for 93 percent of inter-facility transfers (95% CI: 83.8 and 100 percent), which is statistically significantly above the 10 percent deficiency benchmark. Additionally, the OIG determined that for the 12 patients who had an advance directive, providers did not send a copy to the receiving facility.⁹⁵ These deficiencies may result in suboptimal treatment decisions by the receiving facility that compromise quality of care. The Nurse Manager of Urgent Care stated that staff sent active medication lists to receiving facilities but did not document it in the electronic health records. For advance directives, the Deputy Chief of Staff, Healthcare and Business Operations reported believing that sending the Maryland Order for Life Sustaining Treatment to the receiving facility, instead of the advance directive, met the

⁹⁴ VHA Directive 1094.

⁹⁵ Confidence intervals are not included because the data represents every patient in the study population.

requirement. Due to the low number of patients identified for the advance directive requirement, the OIG made no recommendation.

Recommendation 6

6. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure that transferring providers send patients' active medication lists to receiving facilities during inter-facility transfers.

Healthcare system concurred.

Target date for completion: December 2022

Healthcare system response: The COS and ADPCS evaluated and determined no additional reasons for noncompliance. The COS and ADPCS will continue to ensure a monthly chart review of 30 charts or 100% if less than 30 transfers for compliance with VHA Directive 1094 (transferring providers send patients' active medication lists to receiving facilities during interfacility transfers) to ensure 90% compliance sustained over 6 months or two quarters. Deputy Chief of Staff/ designee will present the data quarterly to the Executive Quality Council (EQC) quarterly.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at both sending and receiving facilities.⁹⁶ The OIG did not find evidence of this communication in an estimated 61 percent of inter-facility transfers (95% CI: 46.7 and 75.6 percent), which is statistically significantly above the 10 percent deficiency benchmark. This could result in nurses at the receiving facility lacking the information needed to care for patients. The interim Performance Measures Manager and Nurse Manager of Urgent Care stated that nurses did not communicate with receiving facility staff if the provider had already shared patient information with them. In addition, the Nurse Manager of Urgent Care reported that nurses did not document when they were unable to contact nursing staff at receiving facilities.

Recommendation 7

7. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that nurse-to-nurse communication occurs between sending and receiving facilities.

⁹⁶ VHA Directive 1094.

Healthcare system concurred.

Target date for completion: December 2022

Healthcare system response: The COS and ADPCS evaluated and determined no additional reasons for noncompliance. The COS and ADPCS will continue to ensure a monthly chart review of 30 charts or 100% if less than 30 transfers for compliance with VHA Directive 1094 (nurse-to-nurse communication occurs between sending and receiving facilities) to ensure 90% compliance sustained over 6 months or two quarters. Deputy Chief of Staff/ designee will present the data quarterly to the Executive Quality Council (EQC) quarterly.

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.”⁹⁷ 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.”⁹⁸ 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 team⁹⁹
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings¹⁰⁰
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction¹⁰¹
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants¹⁰²

⁹⁷ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

⁹⁸ VHA Directive 2012-026.

⁹⁹ 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.”

¹⁰⁰ 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.”

¹⁰¹ 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.”

¹⁰² 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.¹⁰³ VHA also requires that employee threat assessment team members complete the appropriate team-specific training.¹⁰⁴ 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 healthcare system generally met requirements for the management of disruptive and violent behavior. However, the OIG identified a deficiency with staff training.

VHA requires employees to complete prevention and management of disruptive behavior training based on the risk level assigned to their work areas.¹⁰⁵ The OIG found that 16 of 30 employees (53 percent) did not complete the required trainings for their work areas. This could result in employees' lack of awareness, preparedness, and precautions when responding to disruptive behavior incidents. The Assistant Chief of Social Work reported that system leaders and infection control managers instructed employees to cease in-person trainings to follow recommended social distancing guidelines during the pandemic.

¹⁰³ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

¹⁰⁴ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

¹⁰⁵ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*.

Recommendation 8

8. The System Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.¹⁰⁶

Healthcare system concurred.

Target date for completion: February 2023

Healthcare system response: System Director evaluated and determined no additional reasons for noncompliance. System Director will continue to ensure 90% compliance is sustained over 6 consecutive months or two consecutive quarters. The VAMHCS [VA Maryland Health Care System] staff will complete all required Prevention and Management of Disruptive Behavior (PMDB) training based on their risk level assigned to the areas where they work using Workforce Behavior Assessment (WBRA) and VA Directives. Social Work Chief/designee will present the PMDB data to Executive Quality Council (EQC) quarterly.

¹⁰⁶ 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 healthcare system, the OIG conducted a detailed review of eight clinical and administrative areas and provided eight recommendations on issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. 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 eight OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the System Director, Chief of Staff, and ADPCS. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> • 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 healthcare system response • VHA performance data (healthcare system) • VHA performance data (CLC) 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
COVID-19 Pandemic Readiness and Response	<ul style="list-style-type: none"> • Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback • Vaccine administration 	<p>The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.</p>	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program 	<ul style="list-style-type: none"> • The Peer Review Committee recommends improvement actions for Level 3 peer reviews. 	<ul style="list-style-type: none"> • Peer reviewers use at least one of the nine aspects of care for evaluations. • The Peer Review Committee completes final peer reviews within 120 calendar days from the date it is determined a peer review is required, or the System Director approves any necessary extensions in writing.
RN Credentialing	<ul style="list-style-type: none"> • RN licensure requirements • Primary source verification 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Medication Management: Remdesivir Use in VHA	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	<ul style="list-style-type: none"> • Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Transferring providers complete all elements of the VA <i>Inter-Facility Transfer Form</i> or a facility-defined equivalent note in the electronic health record. • Transferring providers send patients' active medication lists to receiving facilities during inter-facility transfers. • Nurse-to-nurse communication occurs between the sending and receiving facility. 	<ul style="list-style-type: none"> • Staff monitor and evaluate all transfers as part of VHA's Quality Management Program.
High-Risk Processes: Management of Disruptive and Violent Behavior	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1b) affiliated healthcare system reporting to VISN 5.¹

**Table B.1. Profile for VA Maryland Health Care System (512)
(October 1, 2017, through September 30, 2020)**

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
Total medical care budget	\$652,396,797	\$688,982,538	\$743,655,430
Number of:			
• Unique patients	53,685	54,629	53,110
• Outpatient visits	709,856	728,079	636,512
• Unique employees§	3,908	3,886	3,886
Type and number of operating beds:			
• Community living center	263	275	275
• Domiciliary	163	150	150
• Intermediate	22	22	22
• Medicine	69	69	69
• Mental health	18	18	10
• Residential rehabilitation	23	23	23
• Surgery	33	33	33
Average daily census:			
• Community living center	143	240	190
• Domiciliary	88	104	75
• Intermediate	2	0	0
• Medicine	54	56	45
• Mental health	15	15	5
• Residential rehabilitation	13	14	14

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 sized research and teaching programs.” An affiliated healthcare system is associated with a medical residency program.

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
<ul style="list-style-type: none"> Surgery 	15	13	9

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

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

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles

The VA outpatient clinics in communities within the catchment area of the healthcare system provide primary care integrated with women’s health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table C.1. provides information relative to each of the clinics.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
Cambridge, MD	512GA	6,264	2,637	Endocrinology Eye Dermatology Infectious disease Nephrology Podiatry Poly-Trauma Pulmonary/ Respiratory disease	–	Nutrition Pharmacy Prosthetics 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.

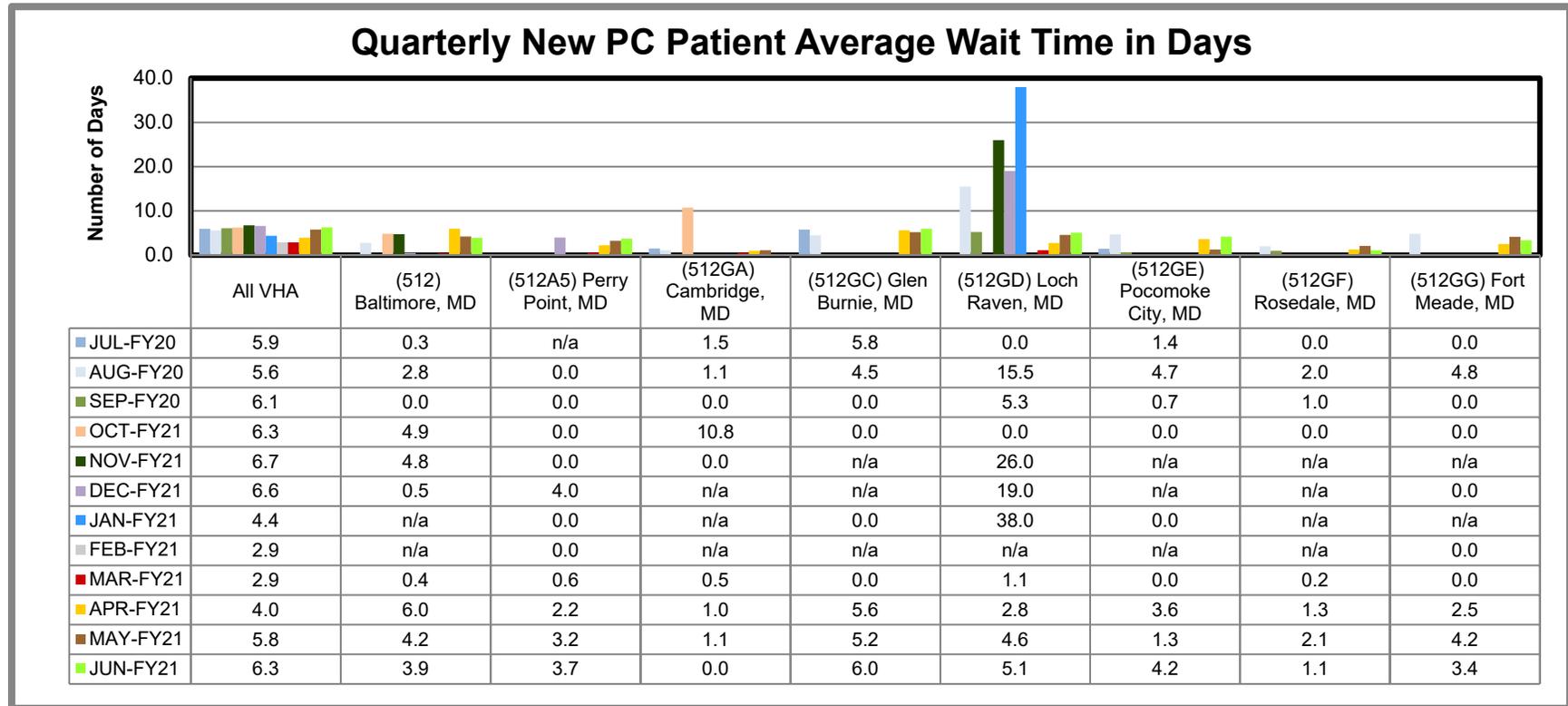
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Glen Burnie, MD	512GC	6,000	2,071	Endocrinology Eye Podiatry Pulmonary/ Respiratory disease	Laboratory and Pathology	Nutrition Pharmacy Weight management
Baltimore, MD	512GD	6,916	3,288	Anesthesia Dermatology Endocrinology Eye General surgery Neurology Orthopedics Podiatry Poly-Trauma Rehabilitation physician	Radiology	Nutrition Pharmacy Prosthetics Weight management
Pocomoke-City, MD	512GE	2,343	865	Dermatology General surgery Infectious disease	–	Nutrition Pharmacy
Rosedale, MD	512GF	4,054	2,099	Dermatology	–	Nutrition Pharmacy
Fort Meade, MD	512GG	5,654	3,056	Eye Pulmonary/ Respiratory disease	–	Nutrition Pharmacy

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Baltimore, MD	512QA	–	3,770	Endocrinology Poly-Trauma	–	–

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

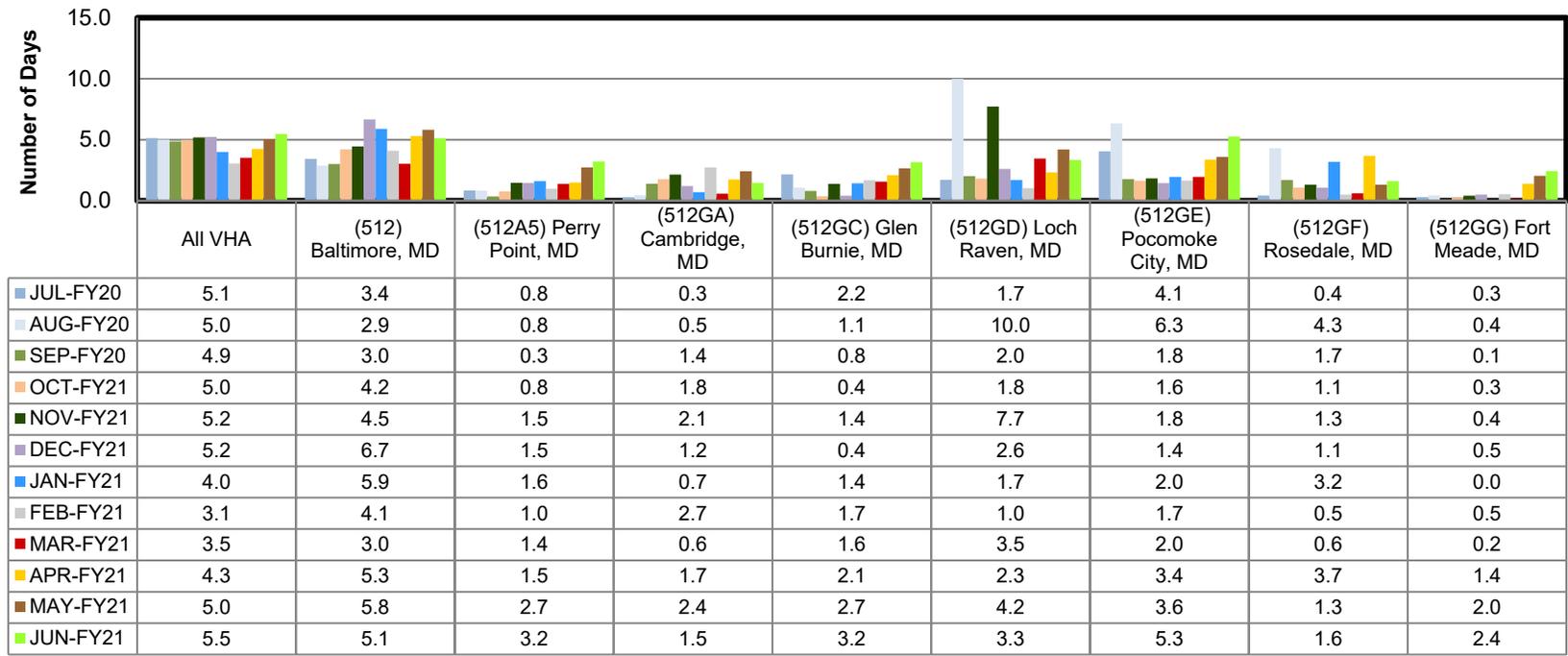


Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, <https://vssc.med.va.gov>, accessed October 21, 2019. (This is an internal website not publicly accessible.)

Note: The OIG omitted (512QA) Baltimore West Fayette Street, MD as no data were reported. The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the healthcare system's explanation for the increased wait times for the Loch Raven, MD community-based outpatient center.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



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

Note: The OIG omitted (512QA) Baltimore West Fayette Street, MD as no data was reported. 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 (HCAHPS)	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
Diabetes (DMG90_ec)	HEDIS outpatient performance measure composite for diabetes care	A higher value is better than a lower value
ED throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Healthcare associated infections	A lower value is better than a higher value
Hospital rating (HCAHPS)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Inpt global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	A higher value is better than a lower value

Measure	Definition	Desired Direction
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH population coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	Care coordination (patient-centered medical home (PCMH))	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care (SC) providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH survey)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.

Measure	Definition
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: June 1, 2022

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

Subj: Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore

To: Director, Office of Healthcare Inspections (54CH01)
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. This memorandum is in response to the Office of Inspector General's draft report entitled Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore. I have reviewed and concur with the findings and recommendations outlined in the draft report.
2. I have reviewed the comments provided by the Medical Center Director, VA Maryland Health Care System, and concur with the corrective actions to the recommendations. Recommendations # 1, 2, 3, 4, 5, 6, 7, and 8 will remain open and in progress.
3. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VISN 5 Quality Management Officer.

(Original signed by:)

Alissa K Stredney for
Robert M. Walton, FACHE
Network Director, VISN 5

Appendix H: System Director Comments

Department of Veterans Affairs Memorandum

Date: June 1, 2022

From: Director, VA Maryland Health Care System (512/00)

Subj: Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore, Maryland

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

1. I would like to express my gratitude to the Office of Inspector General Survey Team for their professional and comprehensive survey. I have reviewed the draft for the Office of Inspector General, Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore, report and concur with the recommendations.
2. The VA Maryland Health Care System is submitting an initial response to Recommendations 1 through 8, associated with the OIG Report: Comprehensive Healthcare Inspection Program at the VA Maryland Health Care System, Baltimore, Maryland. Recommendations 1 through 8 will remain open and in progress.
3. Please convey my appreciation to the survey team for assisting us in our continuing efforts to provide the best care possible to our Veteran patients.

(Original signed by:)

Jonathan R. Eckman, P.E.
System Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
----------------	---

Inspection Team	Debra Naranjo, DNP, RN, Team Leader Christine El-Zoghbi, Ph.D. Tasha Felton Williams, DNP, ACNP Megan Magee, MSN, RN Rhonda Omslaer, JD, BSN Simonette Reyes, BSN, RN Cheryl Walsh, MS, RN
------------------------	--

Other Contributors	Melinda Alegria, AUD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH Robert Wallace, ScD, MPH Elizabeth K. Whidden, MS, APRN
---------------------------	---

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 5: VA Capitol Health Care Network
System Director, VA Maryland Health Care System (512/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Ben Cardin, Chris Van Hollen
U.S. House of Representatives: Anthony Brown; Andy Harris, M.D.; Steny Hoyer; Kweisi Mfume; Jamie Raskin; Dutch Ruppersberger; John Sarbanes; David Trone

OIG reports are available at www.va.gov/oig.