



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the Hershel
"Woody" Williams VA
Medical Center
in Huntington, West Virginia



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Figure 1. Hershel “Woody” Williams VA Medical Center in Huntington, West Virginia.

Source: <https://www.va.gov/huntington-health-care/locations/> (accessed April 13, 2022).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CI	confidence interval
COVID-19	coronavirus disease
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
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 Hershel “Woody” Williams VA Medical Center and related outpatient clinics in Kentucky, Ohio, and West Virginia. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

The OIG team looks at leadership and organizational risks, and at the time of the inspection, focused on the following additional 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 Hershel “Woody” Williams VA Medical Center during the week of August 9, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors’ ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center’s performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help this medical center and other Veterans Health

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).”

Administration (VHA) 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 six recommendations to the Medical Center 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 medical center’s leadership team consisted of the Medical Center Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. The medical center’s leaders had worked together for over one year. The Director, who was permanently assigned in February 2014, was the most tenured leader. The Chief of Staff, who was assigned in June 2020, was the newest member of the leadership team. The Associate Director for Patient Care Services and Associate Director had served in their positions since July 2017 and 2018, respectively.

Organizational communications and accountability were managed through a committee reporting structure, with Executive Leadership Board oversight of several working groups. The Director served as the chairperson of the board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. Leaders monitored patient safety and care through the Quality, Safety & Value Council, which was responsible for tracking and trending quality of care and patient outcomes.

The OIG reviewed survey results and concluded that employees were generally satisfied with their executive leaders. However, the Director had an opportunity to decrease staff feelings of moral distress at work.² Although selected patient experience survey scores generally reflected similar or higher care ratings than the VHA averages, leaders appeared to have an opportunity to improve female patients’ patient-centered medical home (primary care) access.

The inspection team also reviewed accreditation agency findings and did not identify any substantial organizational risk factors. However, the OIG noted concerns regarding leaders conducting institutional disclosures for all sentinel events.³

² “2020 VA All Employee Survey (AES): Questions by Organizational Health Framework,” VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSI65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The 2020 All Employee Survey defines moral distress as being “unsure about the right thing to do or could not carry out what you believed to be the right thing.”

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

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.”⁴ The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures. In individual interviews, the leaders were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.⁵

Quality, Safety, and Value

The medical center complied with the requirements for a committee responsible for quality, safety, and value oversight functions and protected peer reviews.⁶ However, the OIG identified weaknesses in Systems Redesign and Improvement Program and surgical work group processes.

Medication Management

The OIG team observed compliance with many elements of expected performance, including staff availability to receive remdesivir shipments and required testing completed prior to medication administration. However, the OIG found deficiencies with patient/caregiver education.

Care Coordination

Generally, the medical center complied with many of the requirements for inter-facility transfers. However, the OIG identified deficiencies with completion of all required elements of the VA

⁴ “Strategic Analytics for Improvement and Learning (SAIL) Value Model,” VHA Support Service Center, accessed March 6, 2020, <https://vssc.med.va.gov>. (This is an internal website not publicly accessible.)

⁵ 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.

⁶ 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.

Inter-Facility Transfer Form or facility-defined equivalent and transmission of patients’ advance directives to receiving facilities.⁷

High-Risk Processes

The medical center met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified a deficiency with Disruptive Behavior Committee meeting attendance.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued six recommendations for improvement to the Medical Center 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 medical center. The intent is for medical center leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes F and G, pages 55–56, and the responses within the body of the report for the full text of the directors’ comments). The OIG considers recommendation 1 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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⁷ 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.

Contents

Abbreviations	ii
Report Overview	iii
Inspection Results	iv
Purpose and Scope	1
Methodology	3
Results and Recommendations	4
Leadership and Organizational Risks.....	4
Recommendation 1	20
COVID-19 Pandemic Readiness and Response.....	22
Quality, Safety, and Value	24
Recommendation 2	27
Recommendation 3	28
Recommendation 4	28
Registered Nurse Credentialing	30
Medication Management: Remdesivir Use in VHA	32
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	35
Care Coordination: Inter-facility Transfers.....	37
Recommendation 5	38

High-Risk Processes: Management of Disruptive and Violent Behavior	40
Recommendation 6	42
Report Conclusion.....	43
Appendix A: Comprehensive Healthcare Inspection Program Recommendations	44
Appendix B: Medical Center Profile	47
Appendix C: VA Outpatient Clinic Profiles	48
Appendix D: Patient Aligned Care Team Compass Metrics	50
Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions	52
Appendix F: VISN Director Comments	55
Appendix G: Medical Center Director Comments	56
OIG Contact and Staff Acknowledgments	57
Report Distribution	58



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 Hershel "Woody" Williams VA Medical Center and related outpatient clinics examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.¹

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

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

As such, to examine risks to patients and the organization, the OIG focused on core processes in the following 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 and urgent care center suicide risk screening and evaluation)
7. Care coordination (spotlighting inter-facility transfers)
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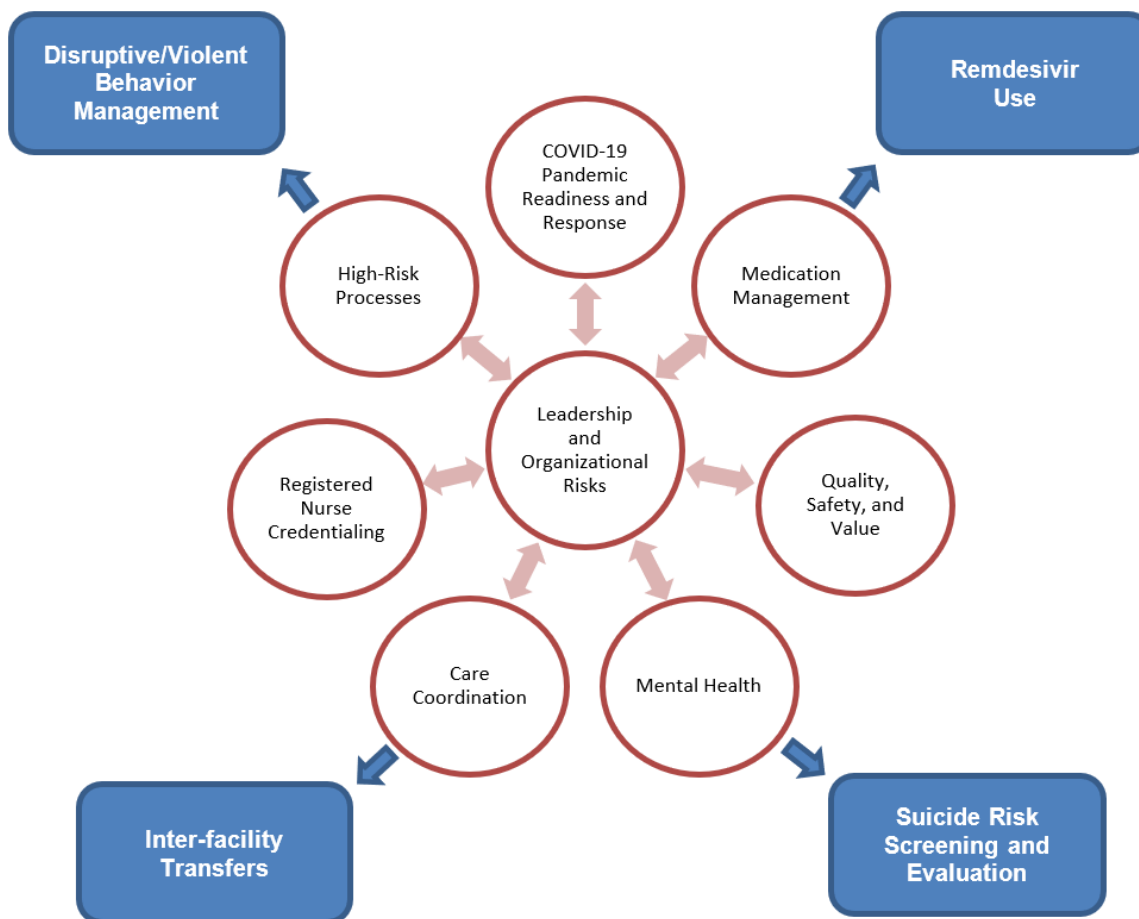


Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.
Source: VA OIG.

Methodology

The Hershel “Woody” Williams VA Medical Center also provides care through multiple outpatient clinics in Kentucky, Ohio, and West Virginia. Additional details about the types of care provided by the medical center can be found in appendixes B and C.

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

The inspection examined operations from August 12, 2017, through August 13, 2021, the last day of the unannounced multiday evaluation.⁷ During the virtual site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG’s hotline management team for further review.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.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 medical center leaders complete corrective actions. The Medical Center Director’s responses to the report recommendations appear within each topic area. The OIG accepted the action plans that 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 medical center’s risks, the OIG considered several indicators:

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

Executive Leadership Position Stability and Engagement

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

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

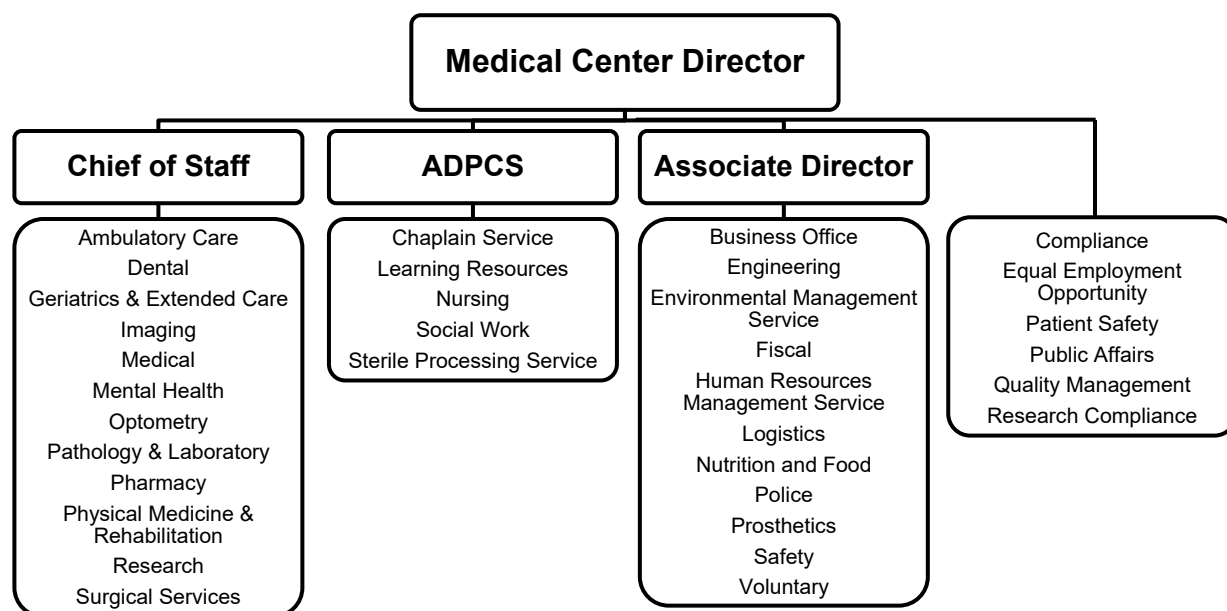


Figure 3. Medical center organizational chart.

Source: Hershel “Woody” Williams VA Medical Center (received August 10, 2021).

At the time of the OIG inspection, the executive team had worked together for over one year, although the Director and two other team members had been in their positions for several years (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	February 23, 2014
Chief of Staff	June 21, 2020
Associate Director for Patient Care Services	July 9, 2017
Associate Director	July 22, 2018

Source: Hershel “Woody” Williams VA Medical Center Senior Strategic Business Partner (received August 10, 2021).

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

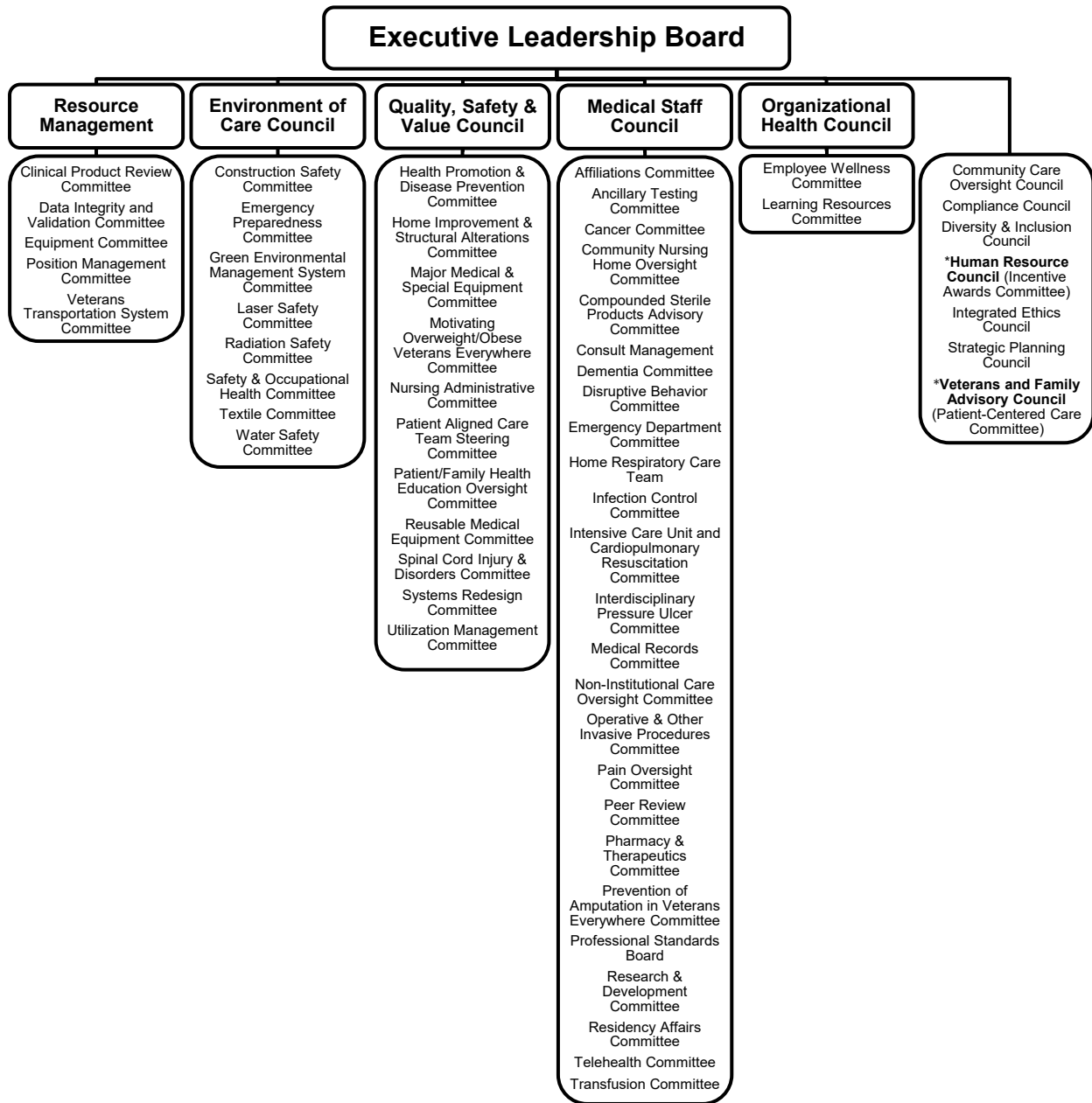


Figure 4. Medical Center committee reporting structure.

Source: Hershel “Woody” Williams VA Medical Center (received August 10, 2021).

*The bolded titles in the far-right column of the committee chart denote the two additional councils that report directly to the Executive Leadership Board, with their reporting subcommittees in parentheses.

To help assess the medical center executive leaders’ engagement, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the 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 medical center’s FY 2020 annual medical care budget of \$380,111,615 increased approximately 25 percent compared to the previous year’s budget of \$304,047,044.¹¹ When asked about the effect of this change on the medical center’s operations, the Director indicated that it had minimal effects because the operations cost also increased. The Director reported that there were not enough general funds to support Care in the Community and Veterans Access, Choice, and Accountability programs, and leaders had not received guidance on how to address the shortage.¹² The Director also acknowledged that the medical center received about \$4.5 million for pandemic-related expenses, which were used to hire additional staff.

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 At the time of the OIG inspection, the leaders reported that the top clinical staffing shortages remained primarily unchanged, but the ADPCS added that biomedical engineering and psychiatry were now occupational staffing shortages. The Chief of Staff reported hiring a urologist in 2020 and a hematologist/oncologist, cardiology electrophysiologist, and two endocrinologists who should onboard between September 2021 and July 2022. The Chief of Staff also shared various recruitment strategies used to support other clinical areas, such as offering bonuses and relocation packages for primary care providers and establishing a

¹¹ VHA Support Service Center.

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

¹³ Veterans Access, Choice, and Accountability Act of 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*.

contract with Marshall University to support vascular services. Additionally, the ADPCS stated that a registered nurse salary survey was being conducted to ensure a competitive stance and help with future recruiting.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Hematology/Oncology	1. Medical Supply Aide and Technician
2. Cardiology Non-Invasive	2. –
3. Cardiology-Interventional	3. –
4. Urology	4. –
5. Endocrine and Metabolism	5. –

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 from medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey from October 1, 2019, through September 30, 2020.¹⁹ Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. The OIG found that medical center averages for the selected survey leadership questions were consistently higher than the VHA averages.²⁰ The OIG noted the same trend for all members of the executive team.

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 Director, Chief of Staff, ADPCS, and Associate Director.

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.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Servant Leader Index Composite.*</i>	0–100 where higher scores are more favorable	73.8	76.0	87.9	85.0	80.9	90.0
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	3.9	4.0	4.4	4.2	4.5
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	4.0	4.1	4.2	4.2	4.5
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	4.0	4.3	4.5	4.3	4.6

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

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The medical center averages for the selected survey questions were more favorable than the VHA averages. Scores related to the Chief of Staff, ADPCS, and Associate Director were similar to or better than those for VHA and the medical center. However, the Director had an opportunity to decrease employee feelings of moral distress at work.

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director 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	4.0	4.6	4.4	4.1	4.6
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	4.0	4.0	4.2	4.1	4.0
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	1.0	2.1	1.0	1.0	0.9

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

VHA leaders have articulated that the agency “is committed to a harassment-free health care environment.”²¹ To this end, the Director discussed signing the “Stand Up to Stop Harassment

²¹ “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.

Now!” campaign declaration and implementing diversity and inclusion projects.²² The Director also reported believing that executive leaders must lead by example and demonstrate the values that employees should display.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA’s All Employee Survey responses. The medical center and executive leaders’ averages for the selected survey questions were consistently better than the VHA averages. Leaders 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	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>People treat each other with respect in my workgroup.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	4.0	4.2	4.2	4.2	4.1
All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	4.1	4.2	4.6	4.6	4.4	4.7
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	4.0	4.4	4.2	4.1	4.5

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

Patient Experience

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

²² “Stand Up to Stop Harassment Now!”

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients’ attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the medical center.²³ For this medical center, the overall patient satisfaction survey results generally reflected higher care ratings than VHA averages. Patients appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	69.5	69.8
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	85.3
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	89.6

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 by 2048.²⁴ 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 (primary care), and Specialty Care surveys (see tables 7–9). The results for male and female

²³ Ratings are based on responses by patients who received care at this medical center.

²⁴ “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.

respondents were generally similar to or more favorable than the corresponding VHA averages. However, results also indicated that leaders have an opportunity to improve female patients’ access to primary care. The leaders appeared to be actively engaged with male and female patients (for example, having nurses and providers participate in patient experience improvement initiatives such as “Commit to Sit” in which staff sit down with patients, discuss the plan of care during the visit, and obtain feedback).

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
<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	70.0	65.0
<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	85.1	85.0
<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	90.4	85.0

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

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

†The medical center averages are based on 455 or 461 male and 10 or 11 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
<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	53.6	24.0
<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	62.0	25.1
<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	75.0	71.6

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

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

†The medical center averages are based on 410–1,203 male and 10–35 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
<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	60.8	‡
<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	66.8	60.3
<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	80.2	81.7

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

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

†The medical center averages are based on 345–1,015 male and 7–28 female respondents, depending on the question.

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

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.²⁵

Table 10 summarizes the relevant medical center inspections most recently performed by the

²⁵ “Profile Definitions and Methodology: Joint Commission Accreditation,” *American Hospital Directory*, accessed December 12, 2020, https://www.ahd.com/definitions/prof_accred.html. “The Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff, or reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.”

OIG and The Joint Commission (TJC).²⁶ At the time of the OIG inspection, the medical center had completed action plans for all recommendations for improvement issued since the previous CHIP site visit conducted in August 2017. The OIG team also noted the medical center’s current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.²⁷

Table 10. Office of Inspector General Inspection/The Joint Commission Surveys

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Comprehensive Healthcare Inspection Program Review of the Huntington VA Medical Center, Huntington, West Virginia, Report No. 17-01760-85, January 31, 2018</i>)	August 2017	7	0
TJC Hospital Accreditation	July 2019	23	0
TJC Behavioral Health Care Accreditation		1	0
TJC Home Care Accreditation		2	0
TJC For Cause	July 2021	0	0

Source: OIG and TJC (inspection/survey results received from the Chief, Quality Management on August 10, 2021).

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

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be

²⁶ 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.”

²⁷ 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.

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 August 12, 2017 (the prior OIG CHIP site visit), through August 8, 2021.²⁸

Table 11. Summary of Selected Organizational Risk Factors (August 12, 2017, through August 8, 2021)

Factor	Number of Occurrences
Sentinel Events	6*
Institutional Disclosures	5
Large-Scale Disclosures	0

Source: The Hershel “Woody” Williams VA Medical Center’s Patient Safety Manager provided the sentinel events, the Risk Manager provided the institutional disclosures, and the Director provided the Large-Scale Disclosure attestation (received August 9, 2021).

**The Patient Safety Manager provided a list of 10 sentinel events. However, 4 of the 10 sentinel events occurred at a contract nursing home and are not attributable to the medical center.*

The Director spoke knowledgeably about the adverse event process and explained that the Chief, Quality Management reports all adverse events following the daily morning meeting. The Director also stated that sentinel event determinations are made through discussions with executive leaders and the quality management team (Chief, Quality Management; Patient Safety Manager; and Risk Manager) and reported to the VA National Center for Patient Safety and VISN leaders. The Director added that the decision to conduct an institutional disclosure occurs after the discussion between the executive leaders and quality management team. Furthermore, the Director indicated that the medical center’s process for serious event follow-up includes the

²⁸ 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 Hershel “Woody” Williams VA Medical Center is a mid-high complexity (1c) 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.”

Chief, Quality Management tracking root cause analysis actions through the Quality, Safety & Value Council and providing daily updates to executive leaders.

The OIG reviewed the list of patient safety events and identified a deficiency related to leaders conducting institutional disclosures for all sentinel events. This deficiency is discussed in greater detail in the Findings and Recommendations section.

Veterans Health Administration Performance Data for the Medical Center

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.”²⁹ 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.³⁰

Figure 5 illustrates the medical center’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the medical center’s performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, adjusted length of stay (LOS), rating (of) specialty care (SC) provider, and emergency department (ED) throughput). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, prevention (PRV90_2), stress discussed, and ischemic heart (IHD90_ec)).³¹

²⁹ “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.)

³⁰ “Strategic Analytics for Improvement and Learning (SAIL) Value Model.”

³¹ For information on the acronyms in the SAIL metrics, please see appendix E.

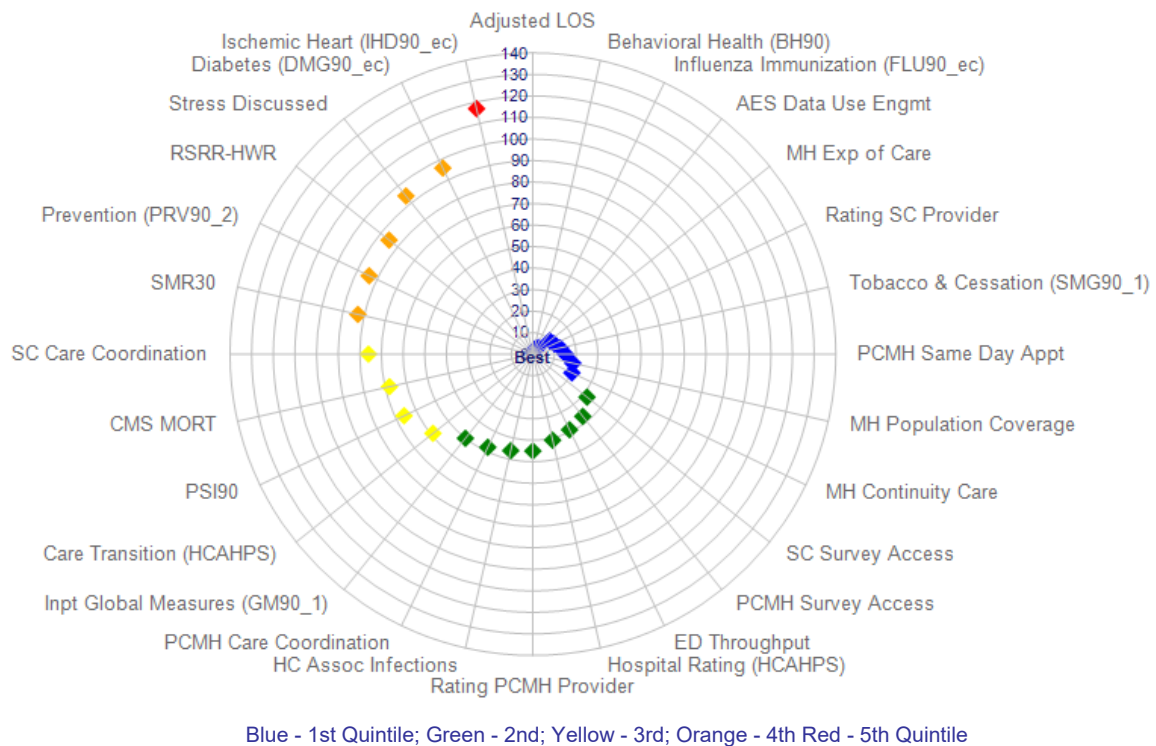


Figure 5. System quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 2020).

Source: VHA Support Service Center.

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

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

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG inspection, the medical center executive leadership team had been stable since the Chief of Staff was assigned in June 2020. The Director served as the chairperson of the Executive Leadership Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning.

Selected employee satisfaction survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated. However, the responses related to the Director pointed toward opportunities to decrease employee feelings of moral distress at work. Although patient experience survey results generally reflected similar or higher care ratings than the VHA averages, results also revealed that female patients were not satisfied with their access to primary care compared to female

VHA patients nationally. In addition, the executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used in the SAIL model.

The OIG’s review of the medical center’s accreditation findings did not identify any substantial organizational risk factors. However, the OIG identified a deficiency related to leaders conducting institutional disclosures for sentinel events.

VHA recognizes that the disclosure of harmful events is “consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence” and therefore requires leaders to inform a patient or the patient’s personal representative when a sentinel event, which results in or is expected to result in death or serious injury, occurs during the patient’s care.³²

The OIG reviewed the six adverse patient events that occurred from August 12, 2017, through August 8, 2021, and determined that all six events met TJC’s definition of a sentinel event.³³ However, the OIG did not find evidence that leaders conducted an institutional disclosure for five of the six sentinel events. The failure to perform an institutional disclosure can reduce patients’ trust in the organization. The Risk Manager cited unawareness that an institutional disclosure was required for all sentinel events. Although leaders did not conduct institutional disclosures as required, the Patient Safety Manager provided evidence that they completed root cause analyses and implemented actions to mitigate future risks.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures leaders conduct institutional disclosures for all sentinel events.³⁴

³² VHA Directive 1004.08.

³³ Three of the six adverse events resulted in the patient’s death.

³⁴ The OIG reviewed evidence sufficient to demonstrate that medical center leaders had completed improvement actions, and therefore, closed the recommendation before publication of the report.

Medical Center concurred.

Target date for completion: Completed

Medical Center response: The Medical Center Director did not determine any additional reasons for non-compliance.

As previously established, discussion occurs between the Chief, Quality Management, the Patient Safety Manager, and the Medical Center leadership when an event occurs that may be considered a sentinel event per TJC. On September 8, 2021, the following actions were added to the existing process: 1) The Risk Manager was included in discussion of each adverse event and the determination of whether or not the criteria for sentinel event was met, resulting in the need for an institutional disclosure. 2) The Risk Manager follows up with the Chief of Staff in preparation for each institutional disclosure. The Risk Manager receives notification of a sentinel event from the Chief Quality Management, when applicable. The Risk Manager is responsible for monthly monitoring of all sentinel events to ensure a corresponding institutional disclosure is completed, and then reports quarterly to the Quality, Safety & Value Council. Compliance is achieved when 100 percent of the sentinel events identified have had an accompanying institutional disclosure. Two adverse events from September 8, 2021, through March 31, 2022, were identified as meeting TJC criteria for [a] sentinel event. Institutional disclosures for the sentinel events were completed on September 8, 2021, and October 5, 2021, respectively. This reflects 100% compliance.

1. The Numerator equals the number of institutional disclosures completed and documented in the Veteran's electronic health record from September 8, 2021, through March 31, 2022.
2. The Denominator equals the total number of sentinel events identified from September 8, 2021, through March 31, 2022.

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.³⁵ 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.³⁶

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.”³⁷ “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.”³⁸

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

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

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

³⁵ “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>.

³⁶ VHA, Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

³⁷ 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.”

³⁸ 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 medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.³⁹

³⁹ 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.⁴⁰ 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.⁴¹ 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.”⁴²

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

- Review of aggregated quality, safety, and value data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the medical center’s processes for its Systems Redesign and Improvement Program, which supports “VHA’s transformation journey to become a High Reliability Organization.”⁴³ 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.”⁴⁴ 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

⁴⁰ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

⁴¹ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

⁴² Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

⁴³ VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

⁴⁴ VHA Directive 1026.01.

Next, the OIG assessed the medical center’s processes for conducting protected peer reviews of clinical care.⁴⁵ 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.”⁴⁶ Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.⁴⁷ 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 unit⁴⁸
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews⁴⁹
- Quarterly review of the Peer Review Committee’s summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center’s surgical program. The VHA National Surgery Office provides oversight for surgical programs and “promotes systems and practices that enhance high quality, safe, and timely surgical care.”⁵⁰ 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;

⁴⁵ 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.”

⁴⁶ VHA Directive 1190.

⁴⁷ VHA Directive 1190.

⁴⁸ VHA Directive 1190.

⁴⁹ VHA Directive 1190. A peer review is assigned a Level 3 when “most experienced and competent clinicians would have managed the case differently.”

⁵⁰ “NSO Reporting, Resources, & Tools,” VA Surgical Quality Improvement Program, accessed November 21, 2020, <https://dvagov.sharepoint.com/sites/VHANSOVASQIP/SitePages/Default.aspx>. (This is an internal VA website not publicly accessible.)

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs.”⁵¹ The medical center’s performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- 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 events⁵²

The OIG reviewers interviewed senior managers and key quality, safety, and value employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.⁵³

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions and protected peer reviews. However, the OIG identified weaknesses in Systems Redesign and Improvement Program and surgical work group processes.

VHA requires the Systems Redesign Coordinator to participate on the facility quality management committee to review program data and information.⁵⁴ The OIG interviewed key staff and reviewed the Quality, Safety & Value Council meeting minutes from August 2020 through July 2021, except for November 2020 when the meeting was cancelled. The OIG found that the Systems Redesign Coordinator did not participate in 3 of 11 meetings (27 percent) during the review period. The lack of participation could hinder leadership oversight and result in missed opportunities to identify improvement needs. The Systems Redesign Coordinator reported that personal leave and competing priorities contributed to the inconsistent attendance.

⁵¹ “NSO Reporting, Resources, & Tools.”

⁵² VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

⁵³ For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

⁵⁴ VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures the Systems Redesign Coordinator participates on the Quality, Safety & Value Council.

Medical center concurred.

Target date for completion: September 30, 2022

Medical center response: The Medical Center Director did not determine any additional reasons for non-compliance.

The Systems Redesign Coordinator is a member of the Quality, Safety & Value Council, and has attended 4 of 6 meetings since October 2021 for 67 percent compliance. Beginning June 1, 2022, a member of the Systems Redesign Oversight Committee will serve as the Systems Redesign Coordinator's designee at the Quality, Safety & Value Council meetings, when applicable. Compliance will be monitored monthly by the Chief, Quality Management using the Quality, Safety & Value Council attendance sheet/log. Compliance will be achieved when the Systems Redesign Coordinator, or designee, attendance at the Quality, Safety & Value Council meetings meets or exceeds 90 percent compliance for six consecutive months. The Chief, Quality Management will report the Systems Redesign Coordinator's attendance compliance rate monthly to the Executive Leadership Board (chaired by the Medical Center Director).

1. Numerator equals the Systems Redesign Coordinator or designee's attendance at the Quality, Safety & Value Council meeting(s).
2. Denominator equals the total number of Quality, Safety & Value Council meetings held.

VHA requires medical facility directors to ensure that facilities have a surgical work group that meets at least monthly and documents meeting minutes.⁵⁵ This work group must be chaired by the Chief of Surgery and include the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.⁵⁶ The OIG requested the Facility Surgical Work Group minutes for meetings held from August 2020 through July 2021 and did not find evidence that the group met during 2 of 12 months (17 percent). For the remaining 10 months, the OIG found that the Chief of Staff did not attend 2 of the meetings (20 percent).⁵⁷ The lack of consistent monthly meetings and leader involvement could have resulted in missed opportunities for oversight and review of surgery program data. The Chief of Surgery reported that the Facility Surgical Work Group meetings for September 2020 and May 2021 were cancelled due to the

⁵⁵ VHA Directive 1102.01(2).

⁵⁶ VHA Directive 1102.01(2).

⁵⁷ The Facility Surgical Work Group does not report as a committee to leaders. Veterans Affairs Surgical Quality Improvement Program and other surgical-related items are shared with leaders via the Medical Staff Council.

Annual VISN 5 Surgical Summit that was held during the same months. The Chief of Staff admitted to missing two meetings because of being on leave in January 2021 and unaware of the meeting in February 2021.

Recommendation 3

3. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that the Facility Surgical Work Group meets at least monthly.

Medical center concurred.

Target date for completion: September 30, 2022

Medical center response: The Medical Center Director did not determine any additional reasons for non-compliance.

The Facility Surgical Work Group requirements were reviewed by senior leadership following completion of the OIG Comprehensive Healthcare Inspection Program review on August 13, 2021. Beginning October 13, 2021, the High-Q [High Quality] meeting minutes will document the Facility Surgical Work Group monthly meeting discussions. The Facility Surgical Work Group has met monthly for the past seven months (October through December 2021, and January through April 2022), which represents 100 percent compliance with required monthly meetings. The Chief, Quality Management will receive a copy of the High-Q monthly meeting minutes to ensure compliance and will report the results from the monitoring to the Executive Leadership Board (chaired by the Medical Center Director) monthly. The Medical Center will be considered compliant when the High-Q minutes reflect six consecutive Facility Surgical Work Group meetings with the required core members in attendance, and achieve a compliance rate of 90 percent or greater.

1. The Numerator equals the number of months the High-Q meeting minutes have evidence that the Facility Surgical Work Group met with core members present.
2. The Denominator equals the total number of months the Facility Surgical Work Group was expected to meet.

Recommendation 4

4. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that core members consistently attend Facility Surgical Work Group meetings.

Medical center concurred.

Target date for completion: September 30, 2022

Medical center response: The Medical Center Director did not determine any additional reasons for non-compliance.

The Facility Surgical Work Group requirements were reviewed by senior leadership following completion of the OIG Comprehensive Healthcare Inspection Program review on August 13, 2021. Beginning October 13, 2021, the Facility Surgical Work Group required members were in attendance at each monthly meeting held. This represents 100 percent compliance with requirement for monthly meeting attendance for the required facility staff, which includes the Chief, Surgical Service, the Chief of Staff, the Surgical Quality Improvement Nurse, and the Operating Room (OR) Nurse Manager. The Chief, Quality Management will monitor the attendance of all required core members using the High-Q attendance log each month. The Chief, Quality Management will report the core members attendance to the Executive Leadership Board (chaired by the Medical Center Director) monthly. The Medical Center will be considered compliant when each required member has achieved 100 percent compliance for six consecutive months.

1. The Numerator equals the number of consecutive months each required member of the Facility Surgical Work Group were in attendance.
2. The Denominator equals the total number of months the Facility Surgical Work Group meeting was held and captured in the High-Q meeting minutes.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses 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.”⁵⁸ 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.”⁵⁹

VA requires all registered nurses to hold at least one active, unencumbered license.⁶⁰ Registered nurses who hold a license in more than one state are not eligible for appointment if a state has terminated the license for cause or if the registered nurse voluntarily relinquished the license after written notification from the state of potential termination for cause.⁶¹ 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.⁶² 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.⁶³

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 58 registered nurses hired from July 1, 2020, through July 11, 2021. The OIG determined whether

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

The OIG also reviewed the credentialing files for 30 of the 58 registered nurses to determine whether medical center staff completed primary source verification prior to appointment.

⁵⁸ VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (This directive was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. The two documents contain similar language regarding credentialing procedures.)

⁵⁹ VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

⁶⁰ 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.”

⁶¹ 38 U.S.C. § 7402.

⁶² VHA Directive 2012-030.

⁶³ VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.⁶⁴ 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.⁶⁵

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.⁶⁶ 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.⁶⁷

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."⁶⁸ The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.⁶⁹

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 14 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

⁶⁴ 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.

⁶⁵ Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

⁶⁶ Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*, May 8, 2020.

⁶⁷ 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*.

⁶⁸ 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.

⁶⁹ 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)⁷⁰
 - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)⁷¹
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the medical center addressed many of the indicators of expected performance listed above. However, the OIG found deficiencies with patient/caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, inform patients 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.⁷² Of the 14 patients who received remdesivir, the OIG determined that prior to the patients receiving remdesivir, healthcare providers did not

- give 31 percent of patients or caregivers the *Fact Sheet for Patients and Parents/Caregivers*,
- advise 29 percent of patients or caregivers of the option to refuse remdesivir, or
- inform 29 percent of patients or caregivers of alternatives to remdesivir.

This could have resulted in the patients or caregivers lacking the information needed to make a fully informed decision to receive the medication. The Chief, Medical Service reported that the physicians’ busy schedule treating COVID-19 patients may have affected their documentation in the medical record.

⁷⁰ “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.”

⁷¹ “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.

⁷² VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

Given the FDA’s approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.⁷³

⁷³ Food and Drug Administration, “FDA News Release: FDA Approves First Treatment for COVID-19.”

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.⁷⁴ The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.⁷⁵ However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.⁷⁶

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

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

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

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

- relevant documents;

⁷⁴ “Suicide Prevention: Facts About Suicide,” Centers for Disease Control and Prevention, accessed October 8, 2021, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

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

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

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

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

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

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

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

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

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

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

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 41 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with requirements for inter-facility patient transfers. However, the OIG identified deficiencies with completion of all required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent and transmission of patients’ advance directives to receiving facilities.

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

⁸⁰ VHA Directive 1094.

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

VHA requires that the Chief of Staff and ADPCS ensure referring physicians record “the date and time transfer will occur” on the *Inter-Facility Transfer Form* or facility-defined equivalent note.⁸² The OIG estimated that 54 percent of transfer forms (95% CI: 38.46 and 68.89 percent) did not contain the date and time the transfer would occur, which is statistically significantly above the 10 percent deficiency benchmark. This could result in the unsafe transfer of patients, the inability to accurately monitor and evaluate transfer data, and an incomplete medical record. The Emergency Department Nurse Manager reported believing that the medical center met this requirement because the emergency room nurse’s disposition note is written in the electronic health record when the patient leaves the medical center and displays the date and time automatically.

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 the referring physician completes all required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent note.

Medical center concurred.

Target date for completion: November 30, 2022

Medical center response: The Chief of Staff and Associate Director of Patient Care Services did not determine any additional reasons for non-compliance.

The Utilization Management Specialist will audit a monthly random sample of 30 patients transferred to another facility, or 100 percent if less than 30, to determine compliance for all required elements. The Utilization Management Specialist will report the interfacility compliance rate to the Medical Staff Council monthly. Based on the OIG Comprehensive Healthcare Inspection Program visit that occurred in August 2021, adjustments were made to the items being monitored on August 13, 2021. Compliance will be achieved when each required element reaches 90 percent or greater for six consecutive months to demonstrate sustainment.

1. The Numerator equals the number of completed required elements on VA Form 10-2649A when a patient is transferred to another facility each month.
2. The Denominator equals the total number of inter-facility transfers each month using the Inter-Facility Transfer Form.

⁸² VHA Directive 1094.

VHA requires that the Chief of Staff and ADPCS ensure “all pertinent medical records available, including an active patient medication list and any medications given to the patient prior to transfer [are sent] with the patient, including documentation of the patient’s advance directive, if available.”⁸³ The OIG estimated that providers did not send the patient’s advance directive to the receiving facility for 92 percent of applicable patients (95% CI: 74.98 and 99.98 percent), which is statistically significantly above the 10 percent deficiency benchmark. As a result, there was no assurance that receiving facility staff could immediately determine patient preferences regarding future healthcare decisions in the event the patient no longer had decision-making capability. The Patient Expeditor reported believing that the advance directives were sent to the receiving facility but not captured in the electronic health record. The Patient Expeditor also reported believing they met the requirement even though the patients’ medical records did not include related documentation.

The OIG identified only 13 patients who had an advance directive, and therefore, did not make a recommendation.

⁸³ VHA Directive 1094.

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.”⁸⁴ 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.”⁸⁵ 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 team⁸⁶
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings⁸⁷
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction⁸⁸
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants⁸⁹

⁸⁴ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

⁸⁵ VHA Directive 2012-026.

⁸⁶ 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.”

⁸⁷ 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.”

⁸⁸ 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.”

⁸⁹ 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.⁹⁰ VHA also requires that employee threat assessment team members complete the appropriate team-specific training.⁹¹ The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG found the medical center addressed many of the indicators of expected performance, including development of a disruptive behavior policy, implementation of an employee threat assessment team, and establishment of a disruptive behavior committee. However, the OIG identified a deficiency with Disruptive Behavior Committee meeting attendance.

VHA requires that the Chief of Staff and ADPCS establish a disruptive behavior committee or board that includes a senior clinician chairperson; administrative support staff; and representation from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety or risk management, patient advocacy, and the Union Safety Committee.⁹² The committee or board is responsible for coordinating with clinicians, recommending amendments to the patients' treatment plans that may reduce the patients' risk of violence, collecting and analyzing disruptive patient incidents, identifying system problems, and recommending to the Chief of Staff other actions related to the problem of patient violence.⁹³

The OIG reviewed attendance for Disruptive Behavior Committee meetings held from September 1, 2020, through August 4, 2021, and found that administrative support staff did not attend any of the meetings. Absence of administrative support staff may impede the accomplishment of required tasks. The Chair of the Disruptive Behavior Committee stated that administrative support staff did not attend the meetings because of staffing shortages.

⁹⁰ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

⁹¹ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

⁹² VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, corrected copy February 3, 2011.

⁹³ VHA Directive 2010-053.

Recommendation 6

6. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that required representatives attend the Disruptive Behavior Committee meetings.

Medical center concurred.

Target date for completion: November 30, 2022

Medical center response: The Chief of Staff and Associate Director for Patient Care Services did not determine any additional reasons for non-compliance.

The Disruptive Behavior Committee required members have attended 9 of 14 meetings for a compliance rate of 92 percent from October 5, 2021, through April 19, 2022. However, this does not represent sustained compliance as there were a total of 5 meetings with less than 90 percent compliance for attendance of all required members. The Chief, Quality Management developed an attendance grid to monitor the required members' attendance at the Disruptive Behavior Committee meetings, and will report attendance compliance monthly to the Executive Leadership Board. In March 2022, documentation of attendance was adjusted to reflect the presence of a surrogate for all required members. Training will be completed for designees of the required members on an ad hoc basis. In addition, during the May 17, 2022, Executive Leadership Board meeting, the need for consistent clerical support will be reviewed. The Medical Center will be considered compliant with the requirement when 90 percent or higher compliance for each required member's attendance has been achieved for a total of six consecutive months.

1. The Numerator equals each required member's, or designee's attendance at the bi-monthly Disruptive Behavior Committee meetings.
2. The Denominator equals the total number of meetings held by the Disruptive Behavior Committee.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines six OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Medical Center 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 medical center response • VHA performance data (medical center) 	<ul style="list-style-type: none"> • Leaders conduct institutional disclosures for all sentinel events. 	<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 • Staff feedback • Vaccine administration 	<p>The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.</p>	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Quality, safety, and value committee • Systems redesign and improvement • Protected peer reviews • Surgical program 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The Systems Redesign Coordinator participates on the Quality, Safety, & Value Council. • The Facility Surgical Work Group meets at least monthly. • Core members consistently attend Facility Surgical Work Group meetings.
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"> • Referring physicians complete all required elements of the VA <i>Inter-Facility Transfer Form</i> or a facility-defined equivalent note. 	<ul style="list-style-type: none"> • None
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"> • Required representatives attend Disruptive Behavior Committee meetings.

Appendix B: Medical Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated medical center reporting to VISN 5.¹

**Table B.1. Profile for Hershel “Woody” Williams VA Medical Center (581)
(October 1, 2017, through September 30, 2020)**

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
Total medical care budget	\$304,423,180	\$304,047,044	\$380,111,615
Number of:			
• Unique patients	27,582	26,905	27,336
• Outpatient visits	418,001	414,058	400,617
• Unique employees§	1,433	1,507	1,548
Type and number of operating beds:			
• Medicine	60	60	60
• Surgery	20	20	20
Average daily census:			
• Medicine	19	18	15
• Surgery	3	4	5

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).

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Prestonsburg, KY	581GA	7,809	2,556	Cardiology Endocrinology Infectious disease Neurology	–	Nutrition Pharmacy Social Work Weight Management
South Charleston, WV	581GB	11,440	3,666	Cardiology Dermatology Endocrinology Eye Infectious Disease Neurology	Electrocardiogram (EKG)	Nutrition Pharmacy Social Work Weight Management

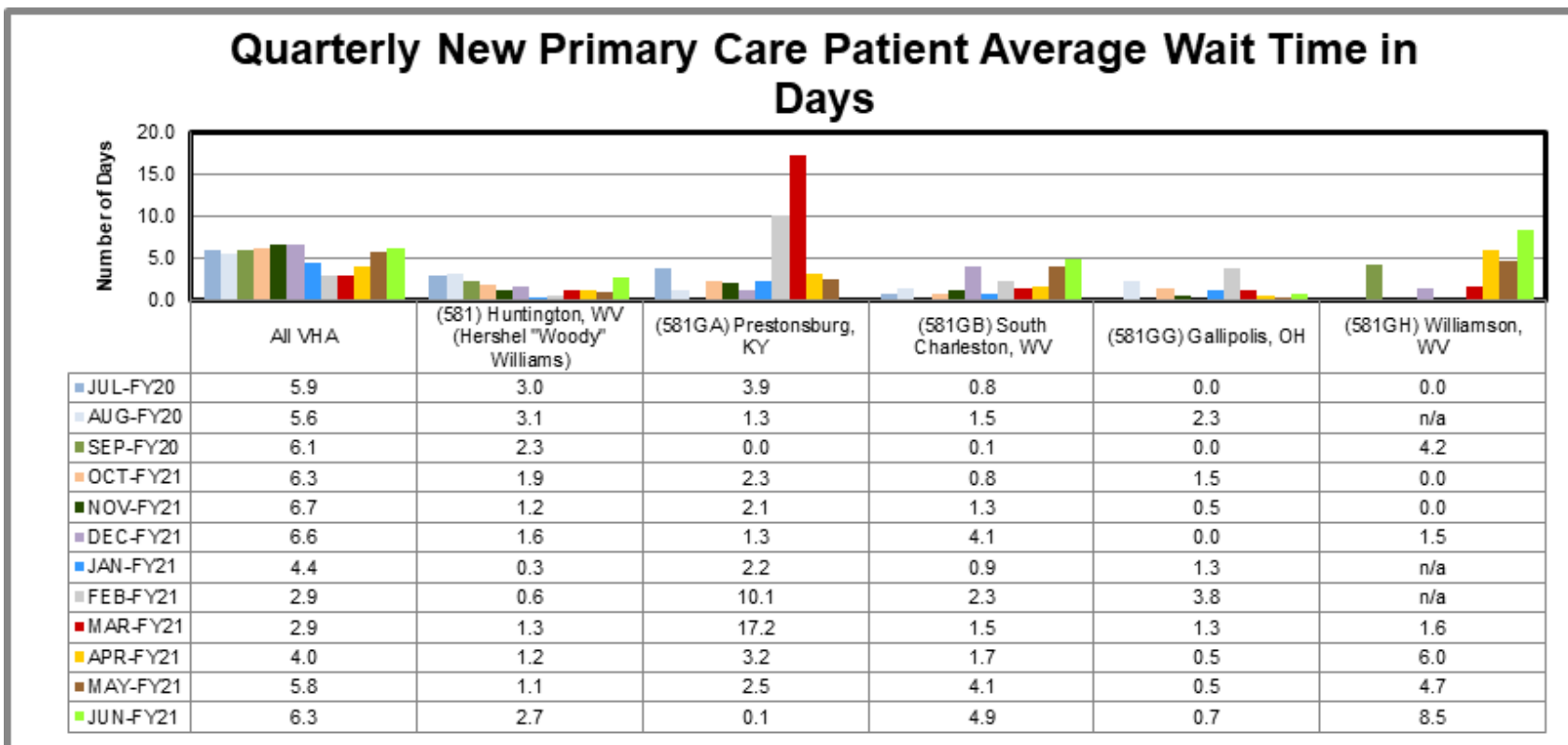
¹ VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a “professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.” Specialty care services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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Gallipolis, OH	581GG	2,683	116	Cardiology Endocrinology Infectious Disease Neurology	–	Nutrition Pharmacy Social Work Weight Management
Williamson, WV	581GH	1,171	4	Cardiology Infectious Disease Neurology	–	Pharmacy Social Work Weight Management
Huntington, WV	581QA	57	66	–	–	–

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

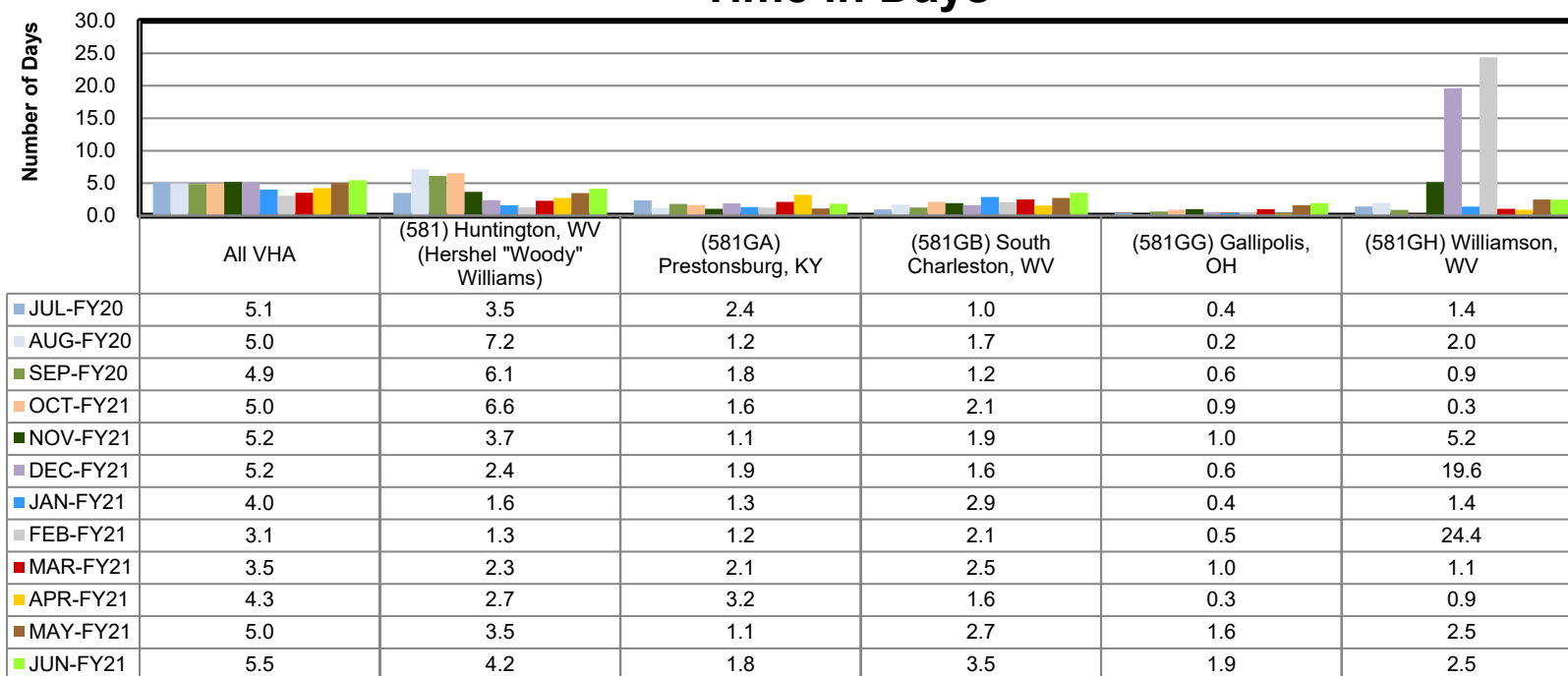


Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, <https://vssc.med.va.gov>, accessed October 21, 2019. (This is an internal website not publicly accessible.)

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

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

Quarterly Established Primary Care Patient Average Wait Time in Days



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

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

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

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use engmt	Sharing and use of All Employee Survey (AES) data	A higher value is better than a lower value
Behavioral health (BH90)	Healthcare Effectiveness Data and Information Set (HEDIS) outpatient performance measure composite related to screening for depression, posttraumatic stress disorder, alcohol misuse, and suicide risk	A higher value is better than a lower value
Care transition (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	Patient-centered medical home (PCMH) care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value
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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 23, 2022

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

Subj: Comprehensive Healthcare Inspection of the Hershel "Woody" Williams VA Medical Center in Huntington, West Virginia

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

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

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG's) draft report entitled - Comprehensive Healthcare Inspection of the Hershel "Woody" Williams VA Medical Center in Huntington, West Virginia.
2. I have reviewed the attached comments provided by the Medical Center Director, Hershel "Woody" Williams VA Medical Center, and concur with the request to close recommendation #1.
3. Furthermore, I have reviewed and concur with the submitted corrective actions for recommendations #2, 3, 4, 5, and 6. These will remain open and corrective actions in progress.
4. Should you require any additional information please contact the VISN 5 network office.

(Original signed by:)

Robert M. Walton, FACHE

Appendix G: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: April 22, 2022

From: Director, Hershel "Woody" Williams VA Medical Center (581/00)

Subj: Comprehensive Healthcare Inspection of the Hershel "Woody" Williams VA Medical Center in Huntington, West Virginia

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

I wish to extend my thanks to the Office of the Inspector General (OIG) and the Comprehensive Healthcare Inspection Program (CHIP) team for the complete and professional review of the organization. The recommendations contained in the report have been reviewed. Attached are the facility responses to the six (6) recommendations, including actions that have been completed, or are in progress, to correct the identified opportunities for improvement.

(Original signed by:)

J. Brian Nimmo, MS, FACHE
Medical Center Director

OIG Contact and Staff Acknowledgments

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