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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Martinsburg VA Medical Center in West Virginia

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Figure 1. *Martinsburg VA Medical Center in West Virginia.*

Source: https://www.va.gov/martinsburg-health-care/locations/
(*accessed May 3, 2022).*

Abbreviations

ADPCS	Associate Director, Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
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 Martinsburg VA Medical Center and related outpatient clinics in Maryland, Virginia, 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 response[1]

2. Quality, safety, and value

3. Registered nurse credentialing

4. Medication management (targeting remdesivir use)

5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)

6. Care coordination (spotlighting inter-facility transfers)

7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual inspection of the Martinsburg VA Medical Center during the week of August 23, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help this medical center and other Veterans Health Administration (VHA) facilities identify

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

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

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued nine recommendations to the Medical Center Director; Chief of Staff; and Associate Director, 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 Director; Chief of Staff; Associate Director, Patient Care Services; and Associate Medical Center Director. The medical center's leaders had worked together for just over one month. However, the Director and Associate Director, Patient Care Services had worked together since July 2020, when the Director assumed the role. The Chief of Staff was appointed in July 2021 after serving as the Chief of Physical Medicine and Rehabilitation. The Associate Director assumed responsibilities of the position in an acting capacity in July 2019 and was permanently assigned in March 2021.

The Director served as the chairperson of the Governing Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. Organizational communications and accountability were managed through a committee reporting structure, with Governing Board oversight of several working groups. 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 medical center's fiscal year 2020 annual medical care budget increased nearly 7 percent compared to the previous year's budget, and the Director reported using the funds to support pandemic-related efforts and community care and hire additional nurses. Executive leaders were also able to discuss strategies to address clinical occupational shortages.

The OIG reviewed survey results and concluded that the Director; Chief of Staff; and Associate Director, Patient Care Services had opportunities to reduce staff feelings of moral distress at work.[2] The OIG also found that male respondents generally rated their care experiences more favorably than male respondents nationally; however, leaders appeared to have an opportunity to improve female respondents' inpatient and specialty care experiences.

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[2] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The 2020 All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

The inspection team also reviewed accreditation agency findings and did not identify any substantial organizational risk factors. However, the OIG identified risk factors related to sentinel events and disclosures of adverse patient events that warranted a recommendation.[3]

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[4] The executive leaders were generally knowledgeable within their scope of responsibilities and tenure about VHA data and factors contributing to poor performance on specific SAIL measures. Leaders also demonstrated an understanding of Community Living Center SAIL measures.[5] In individual interviews, the executive leadership team members spoke 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.[6]

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions and protected peer reviews.[7] However, the OIG identified weaknesses in the Systems Redesign and Improvement Program and the Facility Surgical Workgroup.

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[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." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. An institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") is "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."

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

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

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

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

Medication Management

The OIG team observed compliance with many elements of expected performance, including the availability of staff to receive remdesivir shipments, proper naming of medication orders, provision of required testing prior to medication administration, and reporting of adverse events. However, the OIG found a deficiency with patient or caregiver education.

Care Coordination

Generally, the medical center met expectations for an inter-facility transfer policy and nurse-to-nurse communication. However, the OIG identified deficiencies with staff monitoring and evaluating inter-facility transfers, completing all elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent note, and sending an active medication list and advance directive with the patient to the receiving facility.[8]

High-Risk Processes

The medical center met some of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with Disruptive Behavior Committee meeting attendance and staff training.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued nine recommendations for improvement to the Medical Center Director; Chief of Staff; and Associate Director, Patient Care Services. 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 these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

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

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 69–70, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Martinsburg VA Medical Center and the 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 response[5]

3. Quality, safety, and value

4. Registered nurse credentialing

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

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

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

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

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

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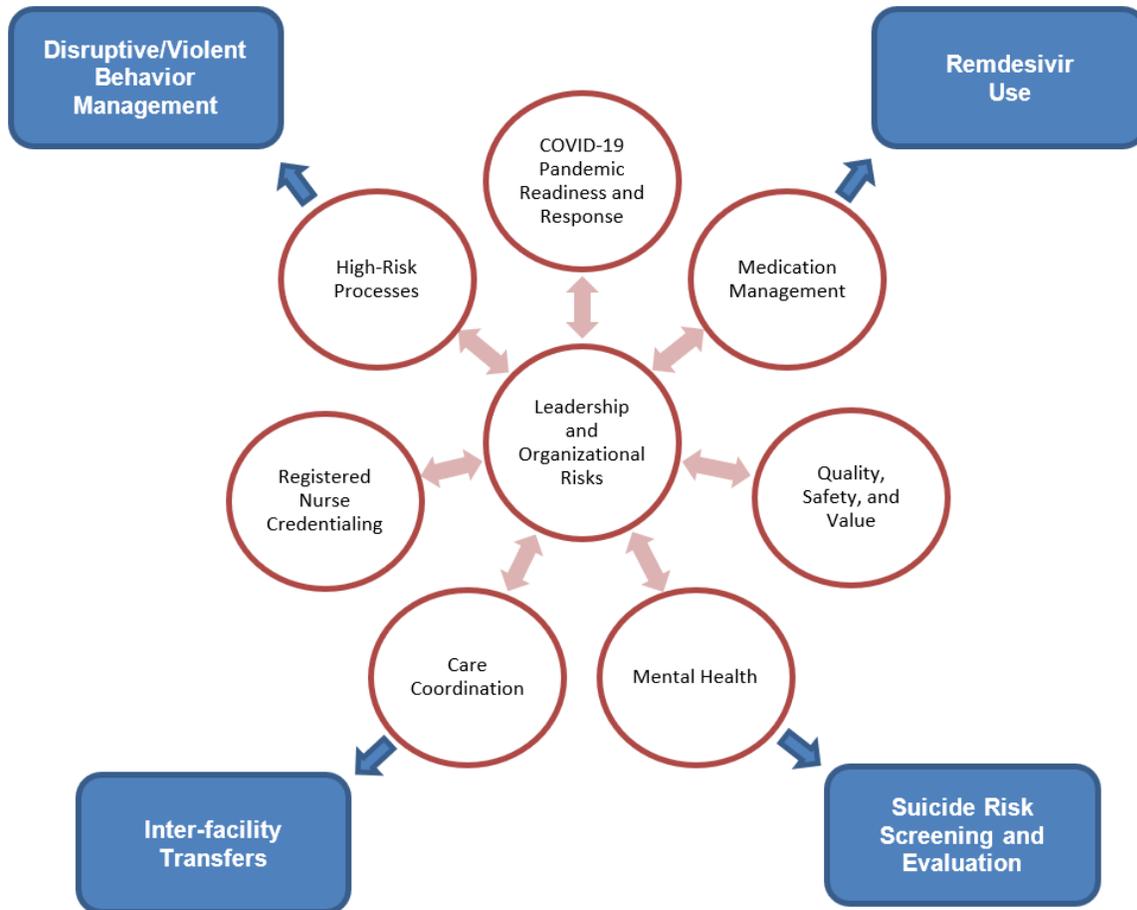
Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. Source: VA OIG.

Methodology

The Martinsburg VA Medical Center also provides care through multiple outpatient clinics in Maryland, Virginia, 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 November 4, 2017, through August 30, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG did not receive any complaints beyond the scope of this inspection.

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.

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[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 completion of 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 medical center's ability to provide care in the clinical focus areas.[10] To assess this medical center's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement

2. Budget and operations

3. Staffing

4. Employee satisfaction

5. Patient experience

6. Accreditation surveys and oversight inspections

7. Identified factors related to possible lapses in care and the medical center response

8. VHA performance data (medical center)

9. VHA performance data (community living center (CLC))[11]

Executive Leadership Position Stability and Engagement

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

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

[11] VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. CLCs, previously known as nursing home care units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.
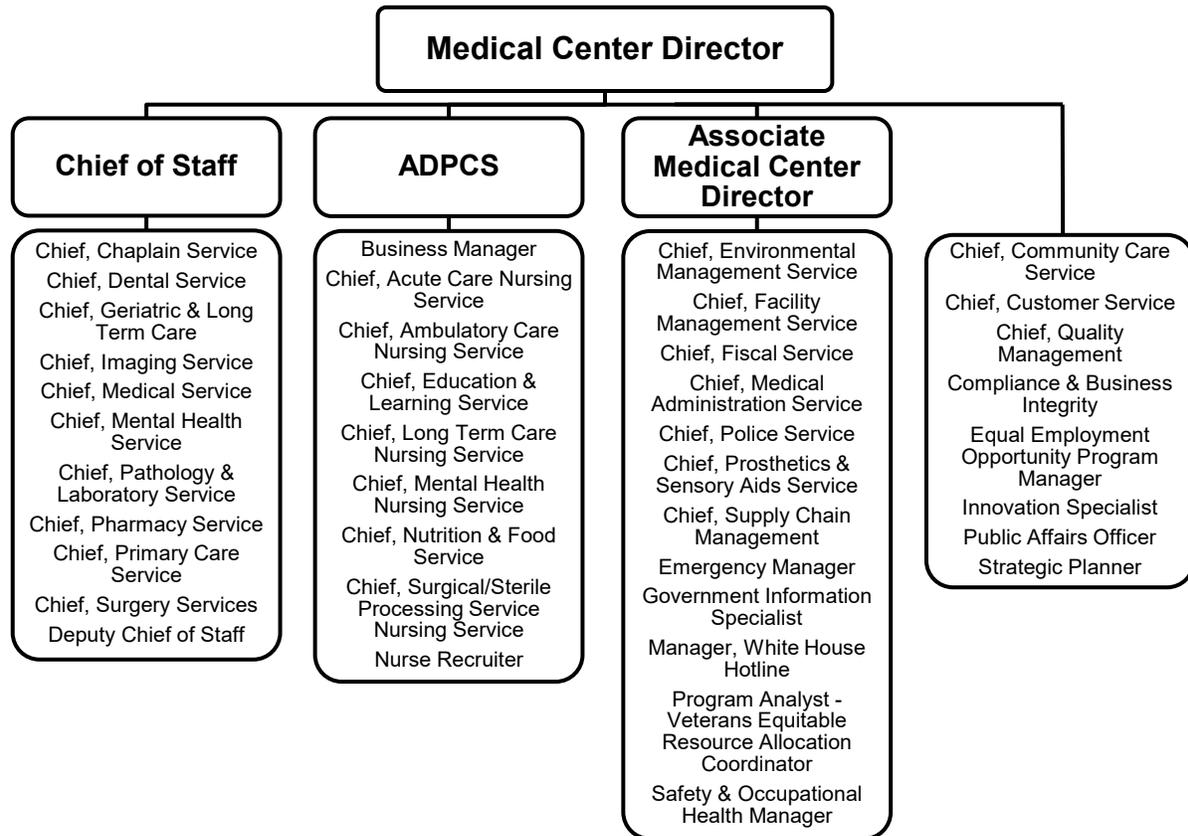
Figure 3. *Medical center organizational chart.*

Source: Martinsburg VA Medical Center (received August 23, 2021).

At the time of the OIG inspection, the executive leaders had worked together for just over one month. However, the Director and ADPCS had worked together since July 2020, when the Director assumed the role. The ADPCS had served since February 2017, and the Chief of Staff was appointed in July 2021, after serving as the Chief of Physical Medicine and Rehabilitation. The Associate Director assumed responsibilities of the position in an acting role in July 2019 and was permanently assigned in March 2021 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	July 19, 2020
Chief of Staff	July 18, 2021
Associate Director, Patient Care Services	February 5, 2017
Associate Medical Center Director	July 21, 2019–March 27, 2021 (acting); March 28, 2021 (permanent)

Source: Martinsburg VA Medical Center Supervisory Human Resources Specialist (received August 24, 2021).

The Director served as the chairperson of the Governing Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Governing Board oversaw various working groups such as the Executive Council for Operations, as well as the Workforce Development; Quality, Safety & Value; and Clinical Practice 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).

Governing Board

Executive Council of the Medical Staff - Performance Improvement

Affiliation Partnership Council
Antimicrobial Stewardship Subcommittee
Cancer Committee
Cardiopulmonary Resuscitation Committee
Caregiver Support Program Steering Committee
Clinical Appeals Board
Clinical Service Chiefs Meeting
Compensation & Pension
Compound Sterile Products Advisory Committee
Credentialing & Privileging Committee
Durable Medical Equipment Committee
Facility Surgical Workgroup
Geriatrics Executive Committee
Health Professional Trainee Oversight Committee
High Consequence Infection Committee
Home Respiratory Care Team
Integrated Clinical Communities
Intensive Care Unit Committee
Invasive Procedure Review Committee
Medical Staff Meeting
Mental Health Executive Committee
Organ Donation
Patient Record Committee
PAVE Committee
Peer Review Committee
Pharmacy & Therapeutics Committee
Reusable Medical Equipment Subcommittee
Risk Management
Social Work Professional Practice Council
Transfusion Review Committee

Executive Council for Operations

Clinical Product Review Committee
Equipment Committee
Position Management Committee
Space Committee

Information Management Council

Clinical Documentation Improvement Committee
Data Validation Committee

Workforce Development Council

Equal Employment Opportunity/ Diversity & Inclusion Subcommittee
Facility Recognition Committee
Medical Center Education Committee
Veterans' Satisfaction Steering Committee

Environment of Care Council

Accident Review Board
Construction Safety Committee
Emergency Management Committee
Facility Safety & Health Committee
Green Environmental Management Systems Committee
Laser Committee
Magnetic Resonance Imaging Safety Committee
Radiation Safety Committee
Textile Committee
Water Safety Committee

Quality, Safety & Value Council

Controlled Substance
ORYX Report
Patient Flow Committee
Patient Safety Committee
SAIL/External Peer Review Program
Service Level Performance Improvement Teams
System Redesign
Tracers
Utilization Management

Clinical Practice Council

Acquired Immunodeficiency Syndrome Advisory Committee
Caregiver Support Program
Clinical Bar Code Multidisciplinary Committee
Connected Care Committee
Disruptive Behavior Committee
Infection Prevention & Control Committee
Nursing Leadership Council
Pain Management Advisory Committee
Research & Development Program
Restraints/ Seclusion
Skin Integrity Team
Spinal Cord Injury Interdisciplinary Treatment Team
Transition and Care Management
Veteran & Family Health Education Committee
Visual Impairment Service Team
Whole Health Committee
Women's Health Committee

Care in the Community Council
Compliance & Business Integrity Committee
High Reliability Organization Workgroup
Integrated Ethics Committee
Strategic Planning Steering Council

Figure 4. Medical Center committee reporting structure.

Source: Martinsburg VA Medical Center (received August 23, 2021).

ORYX = one of the Strategic Analytics for Improvement and Learning (SAIL) measures.

PAVE = Prevention of Amputation for Veterans Everywhere.

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 generally 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 $410,784,430 increased approximately 7 percent compared to the previous year's budget of $384,560,261.[12] When asked about the effect of this change on the medical center's operations, the Director indicated that the budget was adequate and that most of the funds were directed toward COVID-19 and community care. The Director also stated that the general purpose medical care budget did not increase much and that leaders used the increased funds to hire permanent nursing 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] The Director confirmed that medical technologists remained the top clinical occupational shortage and stated that the medical center also had a significant need for imaging technicians. The Director reported approving group retention bonuses and above-minimum pay rates to hire and retain medical technicians. Furthermore, the Director spoke about collaboration efforts with local colleges to help medical support assistants further career goals to become

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[12] VHA Support Service Center.

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

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

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

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

laboratory or ultrasound technicians, with a requirement for them to work at the medical center after graduation.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Medical Technologist	1. Biomedical Engineer

Source: VA OIG.

Employee Satisfaction

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

To assess 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.[20] The OIG found that medical center averages for the survey leadership questions were similar to the VHA averages; however, the Director's scores were consistently higher.[21]

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[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 Medical Center Director.

[20] The 2020 All Employee Survey results are not reflective of employee satisfaction with the current Chief of Staff, who assumed the role after the survey was administered, or the current Director, who was assigned approximately two months prior to survey administration.

[21] 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. Medical Center Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	75.9	79.2	72.1	86.8	67.7
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.4	3.9	3.2	3.5	3.2
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	4.1	3.3	3.4	3.6
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.5	4.1	3.3	3.9	3.8

Source: VA All Employee Survey (accessed July 19, 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.[22] The medical center averages for the selected survey questions were equivalent to the VHA averages. Scores related to the executive leaders were generally similar to or better than those for VHA and the medical center. However, opportunities appeared to exist

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[22] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, and Associate Medical Center Director.

for the Director, Chief of Staff, and ADPCS to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

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. Medical Center Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.8	4.5	3.7	3.9	3.8
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.8	4.2	4.0	4.3	3.8
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)– 6 (Every Day)	1.4	1.4	1.8	1.8	1.7	1.2

Source: VA All Employee Survey (accessed July 19, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[23] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[24] The Director reported communicating a zero-harassment policy to staff.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The medical center and executive leadership team averages for the selected survey questions were similar to or higher 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. Medical Center Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.5	3.8	4.2	3.7
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.1	4.3	3.9	4.4	4.0
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.2	3.8	4.4	3.8

Source: VA All Employee Survey (accessed July 19, 2021).

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[23] "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.

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

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the Martinsburg VA Medical Center.[25] For this medical center, the overall patient satisfaction survey results generally reflected higher care ratings than the VHA averages. Patients appeared satisfied with the primary and specialty care provided.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	66.9
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	86.3
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	86.4

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

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

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

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys (see tables 7–9). The results for male respondents were generally more favorable than the corresponding VHA averages, while inpatient and specialty care scores for female respondents were generally less favorable. The Director stated that appointment times were being expanded because providers reported that females required more time to have their needs addressed. The ADPCS reported that baby showers were provided for female patients; and the Director, ADPCS, and Chief of Staff all shared that they had plans to build a stand-alone women's center.

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

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	67.3	57.0
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	82.4	66.4
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	86.7	62.7

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

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

†The medical center averages are based on 352–356 male and 10 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	54.4	56.2
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	68.5	69.2
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	79.2	68.6

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 608–1,990 male and 51–117 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	53.6	47.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	60.1	40.0
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	79.4	65.9

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

*The VHA averages are based on 63,661–187,441 male and 3,777–10,616 female respondents, depending on the question.
†The medical center averages are based on 453–1,170 male and 15–54 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

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

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

Joint Commission (TJC).[28] At the time of the OIG inspection, medical center leaders had completed action plans for all recommendations for improvement issued since the previous CHIP site visit conducted in October 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.[29] Additional results included the Long Term Care Institute's inspection of the medical center's CLCs.[30]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG *(Postoperative Care Concerns for a Vascular Surgical Patient at the Martinsburg VA Medical Center, West Virginia,* Report No. 17-05381-258, August 16, 2018)	September 2017	3	0
OIG (*Comprehensive Healthcare Inspection Program Review of the Martinsburg VA Medical Center, Martinsburg, West Virginia,* Report No. 17-05409-140, March 29, 2018)	October 2017	5	0
TJC Hospital Accreditation	February 2020	46	0
TJC Behavioral Health Care Accreditation		23	0
TJC Home Care Accreditation		3	0

Source: OIG and TJC (TJC inspection/survey results received from the Chief, Quality Management on August 23, 2021).

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

[29] 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.

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

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

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

Table 11 lists the reported patient safety events from November 4, 2017 (the prior OIG CHIP site visit), through August 23, 2021.[31]

Table 11. Summary of Selected Organizational Risk Factors (November 4, 2017, through August 23, 2021)

Factor	Number of Occurrences
Sentinel Events	10
Institutional Disclosures	53
Large-Scale Disclosures	0

Source: The Martinsburg VA Medical Center's Risk Manager (received August 24, 2021).

The Director explained that the Patient Safety Manager learns about adverse events through the Joint Patient Safety Reporting System and that any staff member can disclose adverse event information to the executive leadership team. Additionally, the Director stated that the Chief,

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[31] 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 Martinsburg 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."

Quality Management and Patient Safety Manager presented adverse events for discussion during the executive leaders' daily morning huddles as events occurred.

The Chief, Quality Management also stated that the Chief of Staff conducted institutional disclosures. For these events the Director reported being informed by reading issue briefs after the institutional disclosures were performed and discussing these events with the Chief, Quality Management. The Director also shared that the executive leadership team tracked and trended adverse patient data.

The OIG reviewed the 10 facility-provided sentinel events and found that the Chief of Staff did not conduct institutional disclosures for 2 of those events. The OIG also reviewed the 53 institutional disclosures and found that leaders did not identify 4 adverse events as sentinel events. These findings are 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 SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[32] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[33]

Figure 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 Martinsburg VA Medical Center's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, stress discussed, patient-centered medical home (PCMH) care coordination, and PCMH same day appointment (appt)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, health care (HC) associated (assoc) infections, mental health (MH) continuity [of] care, and MH experience (exp) of care).[34]

The executive leaders were generally 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 generally able to speak about actions taken during the previous 12 months to maintain or improve organizational performance.

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

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

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

According to the ADPCS, staff removed urinary catheters from patients when they were no longer needed to help decrease the risk of health care associated infections. Regarding the mental health continuity and experience of care measures, the Chief of Staff stated that there may not have been optimal inpatient and outpatient mental health care coordination or consistent provider follow-up. Therefore, the Chief of Staff reported educating providers on referrals and encouraging staff to obtain patients' phone numbers and make primary care appointments before they are discharged.

Blue - 1st Quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th Quintile
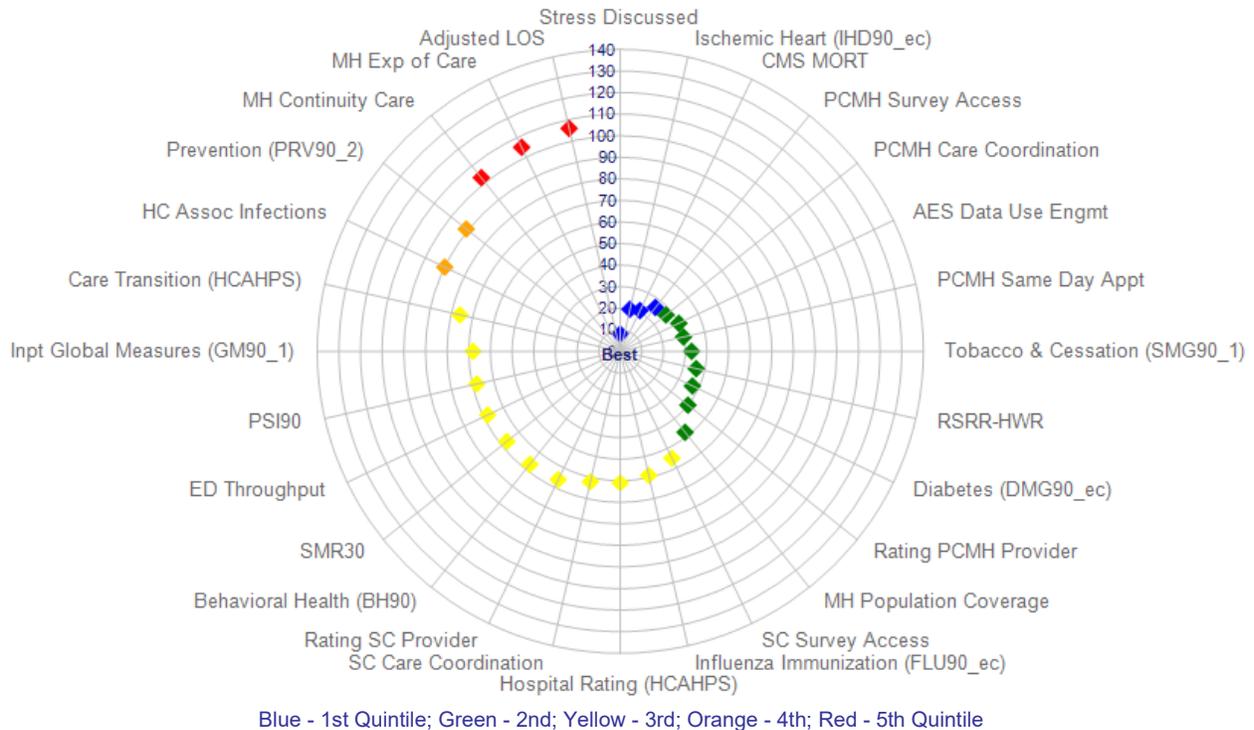
Figure 5. Martinsburg VA Medical Center quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 2020).

Source: VHA Support Service Center.

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

Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[35] The model "leverages much of the same data" used in the Centers for Medicare &

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[36]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of March 31, 2021. Figure 6 displays the Martinsburg VA Medical Center's CLC measures with high performance (blue and green data points) in the first and second quintiles (for example, improvement in function (imprvfnctn)–short-stay (SS), urinary tract infections (UTI)–long-stay (LS), and catheter in bladder (cath) (LS)). Measures in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, newly received antipsychotic (antipsy) medications (SS), falls (LS), and discharged to community (dischcom) (SS)).[37]

The executive leaders were generally knowledgeable about poorly performing CLC SAIL measures and discussed actions taken during the previous 12 months to maintain or improve organizational performance. The Chief of Staff reported that the CLC's large dementia population negatively affected the falls measure and leaders were working on process improvements that included "dementia capable care training" for staff. The ADPCS stated that nurses discuss discharge plans with residents from day one and attributed the low-performing discharged to community measure to residents not having a permanent place to go after discharge or wanting to spend their money on assisted living arrangements.

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

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

Blue - 1st Quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th Quintile
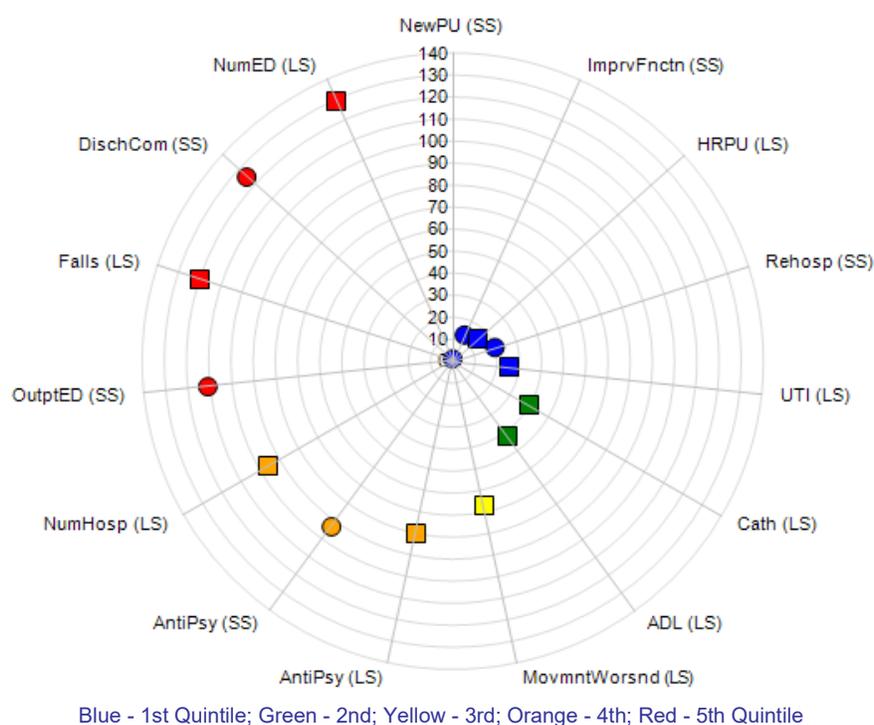
Figure 6. Martinsburg CLC quality measure rankings for FY 2021 quarter 2 (as of March 31, 2021).

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

When the OIG conducted this inspection, the medical center had a leadership team consisting of the Director, Chief of Staff, ADPCS, and Associate Director. The medical center's leaders had worked together for just over one month. However, the Director and ADPCS had worked together since July 2020, when the Director assumed the role. The Director served as the chairperson of the Governing Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning.

The medical center's fiscal year 2020 annual medical care budget increased nearly 7 percent compared to the previous year's budget, and the Director reported using the funds to support pandemic-related efforts and hire additional nurses. The Director also discussed interim strategies to address clinical occupational shortages.

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

Survey results also highlighted opportunities for leaders to decrease employees' feelings of moral distress at work. Patient experience survey data implied that male respondents were generally satisfied with their care but also indicated that leaders had an opportunity to improve female respondents' inpatient and specialty care experiences.

Executive leaders were knowledgeable within their scope of responsibilities and tenure about selected VHA data used by the SAIL and CLC SAIL models. The OIG's review of the medical center's accreditation findings did not identify any substantial organizational risk factors; however, the OIG noted a concern with leaders identifying sentinel events and conducting institutional disclosures.

TJC defines sentinel events as those safety events that reach the patient and result in death, or severe temporary or permanent harm.[38] Furthermore, TJC expects accredited facilities to identify, investigate, and disclose sentinel events to the patient or family.[39] In support of TJC, VHA established the Patient Safety Program to develop a system to prevent patient harm. To accomplish this, all facility staff are responsible for reporting any unsafe condition even if an adverse event has not occurred. In addition, leaders are accountable for identifying sentinel events, conducting a review to determine the root cause, implementing actions to prevent future occurrences, and maintaining an accurate record of all events.[40] Furthermore, VHA recognizes that the disclosure of harmful events is "consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence" and requires leaders to inform or disclose a sentinel event to a patient or patient's personal representative when one occurs.[41]

The OIG reviewed a list of 10 sentinel events that occurred from November 4, 2017, through August 23, 2021, and found that the Chief of Staff did not conduct institutional disclosures for 2 of those events. The failure to perform an institutional disclosure can erode VA's core values and reduce patients' trust in the organization. In one case, one of the two Risk Managers reported that undocumented attempts to conduct an institutional disclosure with the next of kin were unsuccessful. For the remaining case, the same Risk Manager stated that institutional disclosures were not conducted due to COVID-19 Incident Command workload and ongoing orientation of a new staff member.

The OIG also reviewed the 53 institutional disclosures that were conducted during the same time frame and found that for 4 disclosures of adverse events, leaders did not identify them as sentinel

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[38] "Sentinel Events Policy and Procedures," The Joint Commission, accessed March 2, 2021, https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-policy-and-procedures/.

[39] "Sentinel Events Policy and Procedures," The Joint Commission.

[40] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[41] VHA Directive 1004.08.

events.[42] The failure to properly identify sentinel events can prevent leaders from recognizing the need to improve patient safety processes. The Patient Safety Manager stated that although a root cause analysis and institutional disclosure were completed for one adverse event, leaders did not identify it as a sentinel event due to an administrative error. For the remaining three adverse events, the Patient Safety Manager and risk managers stated that they did not believe these falls met TJC's definition of a sentinel event at the time they occurred.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures leaders properly identify adverse events as sentinel events when criteria are met and conduct institutional disclosures, as required.

Medical center concurred.

Target date for completion: September 30, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. Effective August 31, 2021, Risk Management developed a new adverse events spreadsheet to track all the elements reviewed by OIG. This includes supporting documentation such as disclosures and root cause analyses embedded in this tracker. Adverse events are identified via multiple sources, including the Joint Patient Safety Reporting (JPSR) system, where the Patient Safety Analyst reviews JPSRs daily. Adverse events may also be communicated during the daily review of events from the last 24 hours using the Bed Management and Patient Detail Report. The Bed Management and Patient Detail Report is discussed in a standing meeting called Nursing Morning Report, which is held each morning at 7:30 am, except on weekends and holidays. Twenty-four hour reports from the weekend or holiday are reviewed in that meeting the next business day following the weekend or holiday. A Risk Manager attends the Nursing Morning Report meeting. Also, adverse events may be reported via verbal or written methods including phone calls, texts, and emails to any member of the Quality Management/Patient Safety/Risk Management team, or to departmental or health care organization supervisors. Adverse events are identified as sentinel events when criteria are met as described by The Joint Commission. The Patient Safety Manager, Patient Safety Analyst, the two Risk Managers, the Assistant Quality Management Chief, and the Quality Management Chief review adverse events using these criteria and then meet with the Chief of Staff to determine if the adverse event is a sentinel event, using the criteria from The Joint Commission. If an adverse event is deemed a sentinel event, an institutional disclosure process follows, using the standards described in the VHA Directive Disclosure of Adverse Events to Patients (VHA

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[42] The adverse events that leaders did not identify as sentinel events involved three patient falls, which resulted in fractures and required surgical intervention, and the retention of a guidewire that necessitated return to the operating room.

Directive 1004.08). A Risk Manager has scheduled weekly Patient Safety and Risk Management huddles to review events and update the tracker. The elements of the tracker are: Patient Identifier, Full Social Security Number, Date of Birth, Age at Time of Event, Notification Method, Event Date, Event Description, If Injury State Injury, and Corresponding Intervention/If No Injury Place N/A After Description, Date Patient Safety, and Risk Manager Became Aware of Event, Number of Days Between Event and Notification, Sentinel Event, The Joint Commission (TJC) Referral Number and Date/TJC Decision and Date/Name of TJC Contact/Embed Email Communication, Date Sentinel Event Decision Was Made, Rationale for Sentinel Event Decision, Institutional Disclosure, Date of Institutional Disclosure, How Many Days Between Awareness and Institutional Disclosure, Embed Disclosure Note, Quarter Disclosure Completed, RCA [Root Cause Analysis] Completed, RCA Start Date/End Date, Embed RCA, Peer Review, and Embed Peer Review.

Reporting Committee: Adherence to the revised tracker process will be monitored quarterly to ensure compliance and reported by a Risk Manager to the Quality, Safety, and Value Council, which the Medical Center Director chairs. Contained in the Quality, Safety, and Value Council Report is the total number of institutional disclosures in the quarter being reported. This will include the total number of sentinel events per quarter as identified using the VHA criteria listed above, and the total number of corresponding institutional disclosures completed.

Frequency of Monitoring: The quarterly monitoring will continue until compliance is sustained at 90 percent for six consecutive months. The numerator is the number of sentinel events and institutional disclosures identified, and the denominator is the total number of adverse events identified that were reviewed by Patient Safety, Risk Management, and Quality Management Chief/Assistant Chief as a possible Sentinel Event.

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.[43] 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.[44]

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."[45] "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."[46]

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

- Emergency preparedness

- Supplies, equipment, and infrastructure

- Staffing

- Access to care

- CLC patient care and operations

- Vaccine administration

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

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[43] "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.

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

[45] 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."

[46] 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.[47]

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[47] 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.[48] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[49] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[50]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center's committee responsible for 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."[51] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[52] The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator

- Tracking of facility-level performance improvement capability and projects

- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group

- Staff education on performance improvement principles and techniques

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[48] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

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

[50] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

[51] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

[52] VHA Directive 1026.01.

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

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)

- Peer review of all applicable deaths within 24 hours of admission to the hospital

- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[56]

- Completion of final reviews within 120 calendar days

- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[57]

- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

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

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

[54] VHA Directive 1190.

[55] VHA Directive 1190.

[56] VHA Directive 1190.

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

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

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

- Assignment and duties of a chief of surgery

- Assignment and duties of a surgical quality nurse (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 events[60]

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.[61]

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 the Systems Redesign and Improvement Program and Facility Surgical Workgroup.

VHA requires a systems redesign and improvement coordinator to participate on the VISN Systems Redesign Review Advisory Group to review program data and information.[62] The OIG found that from April through August 2021, a systems redesign and improvement coordinator, referred to as the Systems Redesign Health Systems Specialist, did not participate in three of five VISN Systems Redesign Review Advisory Group meetings (60 percent). The lack of participation could hinder leadership oversight and result in missed opportunities to identify improvement needs. The Systems Redesign Health Systems Specialist and Chief, Quality Management attributed the deficiency to competing COVID-19 duties and scheduling conflicts.

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

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

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

[62] VHA Directive 1026.01, *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 Health Systems Specialist participates on the VISN Systems Redesign Review Advisory Group.

Medical center concurred.

Target date for completion: December 31, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. The Chief, of Quality Management is now the assigned representative appointed to the VISN 5 Systems Redesign Review Advisory Group to represent the Martinsburg VA Medical Center System Redesign & Improvement Coordinator when the Martinsburg VA Medical Center System Redesign & Improvement Coordinator is not available to attend the VISN 5 Systems Redesign Review Advisory Group meetings. The Martinsburg VA Medical Center System Redesign & Improvement Coordinator will ensure attendance is properly recorded in the VISN 5 Systems Redesign Review Advisory Group attendance sheet.

Reporting Committee: The compliance for monitoring attendance of the Martinsburg VA Medical Center System Redesign & Improvement Coordinator to the VISN 5 System Redesign Review Advisory Group will be reported quarterly to the Quality, Safety, and Value Council which the Medical Center Director chairs.

Frequency of Reporting: Monthly attendance of the Martinsburg VA Medical Center System Redesign and Improvement Coordinator (or representative) to the VISN 5 System Redesign Review Advisory Group is documented in the attendance sheet monthly of the VISN 5 System Redesign Review Advisory Group. The minutes are distributed electronically to the members monthly. Martinsburg VA Medical Center System Redesign & Improvement Coordinator attendance is 100 percent each month from September 2021 through February 2022 (4 out of 4 meetings attended). The numerator is the number of times the Martinsburg VA Medical Center System Redesign & Improvement Coordinator attended the meetings, and the denominator is the number of VISN 5 Systems Redesign Review Advisory Group meetings.

VHA requires medical facilities with surgery programs to have a surgical work group that meets at least monthly and includes the Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[63] The OIG reviewed all available Facility Surgical Workgroup meeting minutes from August 2020 through July 2021 and found that the Chief of Staff did not attend 3 of 11 meetings (27 percent).[64] The lack of core member attendance could result in the review and analysis of surgery program data without the

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[63] VHA Directive 1102.01(2).

[64] The Facility Surgical Workgroup did not meet in December 2020.

perspectives of key staff. The Chief of Staff acknowledged awareness of the requirement and reported that the absences were due to scheduling conflicts.

Recommendation 3

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

Medical center concurred.

Target date for completion: July 31, 2022

Medical center response: The Medical Center Director and the Chief of Staff evaluated and determined no additional reasons for noncompliance. The Chief, of Surgery Services serves as Chair of the Facility Surgical Workgroup and is joined at the meetings by the required core members: Chief of Staff, Surgical Quality Nurse, and Facility Operation Room Nurse Manager. If one of the required core members is not in attendance, an official designee will be assigned and noted in the minutes or, the meeting will be rescheduled. The Chief of Staff will review and sign the Facility Surgical Workgroup minutes.

Reporting Committee: The compliance for monitoring attendance of required core members of the Facility Surgical Work Group will be reported monthly by the chair of the Facility Surgical Work Group to the Quality, Safety, and Value Council, which is chaired by the Medical Center Director.

Frequency of Monitoring: Monthly monitoring of the Facility Surgical Workgroup attendance of the core members until a 90 percent compliance rate is demonstrated for six consecutive months. From September 2021 through February 2022 there has been 100 percent compliance each month for each of the core members (6 out of 6 meetings). The numerator is the number of times the core members of the Facility Surgical Workgroup attended the meetings, and the denominator is the number of Facility Surgical Workgroup meetings.

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."[65] 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."[66]

VA requires all registered nurses to hold at least one active, unencumbered license.[67] 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.[68] 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.[69] 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.[70]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 65 registered nurses hired from July 1, 2020, through July 18, 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 30 of the 65 registered nurses' credentialing files to determine whether medical center staff completed primary source verification prior to the appointment.

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

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

[67] 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."

[68] 38 U.S.C. § 7402.

[69] VHA Directive 2012-030.

[70] 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.[71] 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.[72]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[73] 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.[74]

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."[75] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[76]

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 18 patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments

- Medication orders used proper name

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[71] 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.

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

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

[74] 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.*

[75] 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.

[76] 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

   o Potential pregnancy

   o Kidney assessment (estimated glomerular filtration rate)[77]

   o Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[78]

- Patient/caregiver education provided

- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the medical center addressed most of the indicators of expected performance, including the availability of staff to receive remdesivir shipments, proper naming of medication orders, provision of required testing prior to medication administration, and reporting of adverse events. However, the OIG identified a deficiency with patient or caregiver education prior to remdesivir administration.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, inform patients and/or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients and/or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[79] For the 18 patients who received remdesivir, the OIG determined that healthcare providers did not

- provide any patients or caregivers with the *Fact Sheet for Patients and Parents/Caregivers*,

- inform 61 percent of patients or caregivers that remdesivir was not an FDA-approved medication,

- inform 44 percent of patients or caregivers of the option to refuse the treatment,

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[77] "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."

[78] "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.

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

- inform 44 percent of patients or caregivers of the risks and benefits, or

- advise 83 percent of patients or caregivers of alternatives to receiving remdesivir prior to administration.[80]

This could have resulted in the patient or caregiver lacking the information needed to make a fully informed decision to receive the medication. The Deputy Chief of Staff and an infectious disease physician reported believing that providers communicated the above information to the patients or caregivers prior to remdesivir administration despite the lack of documentation of each individual element within the electronic health records.

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.[81]

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[80] Confidence intervals are not included because the data represents every patient in the study population.

[81] 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.[82] 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.[83] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[84]

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.[85] 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.[86] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

- Completion of suicide safety plans by required staff

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

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

- relevant documents;

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

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

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

[85] 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.

[86] 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 39 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

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[87]

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."[88] 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.[89]

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 46 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 an inter-facility transfer policy and nurse-to-nurse communication. However, the OIG identified deficiencies with staff monitoring and evaluating inter-facility transfers, completing all elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent note, and sending an active medication list and advance directive with the patient to the receiving facility.

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

[88] VHA Directive 1094.

[89] 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 "all transfers are monitored and evaluated as part of VHA's Quality Management Program."[90] The OIG reviewed all available Patient Flow Committee minutes for meetings held from August 1, 2020, through July 31, 2021, and found that 6 of 10 sets of minutes (60 percent) lacked evidence that staff monitored and evaluated patient transfers. Failure to consistently monitor patient transfer data could prevent staff from identifying deficiencies that put patients at risk. The Chief, Acute Care Nursing Service stated the committee was unaware of the requirement to monitor and evaluate transfer data as part of the medical center's quality management program.

Recommendation 4

4. The Chief of Staff and Associate Director, Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure staff monitor and evaluate all patient transfers.

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[90] VHA Directive 1094.

Medical center concurred.

Target date for completion: December 31, 2022

Medical center response: The Chief of Staff and Associate Director, Patient Care Services (ADPCS) evaluated and determined no additional reason for noncompliance. Prior to the OIG CHIP review, the facility had identified this noncompliance and began tracking every inter-facility transfer starting on April 1, 2021. The Patient Flow Coordinator who reports to the ADPCS through the Chief, Acute Care Nursing Service, has the responsibility for tracking and reviewing each open medical record for inter-facility transfer compliance with required documentation. Noncompliant inter-facility transfers are reported monthly to the chiefs of the clinical services (Acute Care, Mental Health, Long Term Care, and Emergency Department) via email and an action plan is requested from the service chiefs. The Patient Flow Coordinator reports the inter-facility transfers data and service submitted action plans monthly to the Patient Flow Committee. The Patient Flow Committee reports to the Quality, Safety, Value Committee. Medical Center Policy (MCP) 11-078 Interfacility Transfers and Referral, which rescinded the Medical Center Memorandum 11-78 Interfacility Transfers and Referral dated January 2019, has been updated and published in the Medical Center Document Control SharePoint. All Martinsburg VA Medical Center staff have 24-hour a day/7 day a week access to this SharePoint site.

Reporting Committee: The compliance for monitoring all patient inter-facility transfers is reported to the Patient Flow Committee chaired by the Patient Flow Coordinator. The Patient Flow Committee reports quarterly to the Quality, Safety, and Values Council of which the Chief of Staff and the Associate Director, Patient Care Services are members.

Frequency of Monitoring: Monthly monitoring of inter-facility transfers has been reported monthly by the Patient Flow Coordinator to the Patient Flow Committee since May 19, 2021. The numerator is the number of monthly inter-facility transfers with complete documentation of all Inter-facility Transfer Note elements. The denominator is the number of monthly inter-facility transfers. Monthly monitoring to ensure 90 percent monthly compliance for six consecutive months.

VHA requires the Chief of Staff and ADPCS to ensure that appropriately privileged providers complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record prior to inter-facility transfers.[91] The OIG estimated that 63 (95% CI: 48.9 to 76.6) percent of the electronic health records reviewed lacked the VA *Inter-Facility Transfer Form* or an equivalent note, which is statistically significantly above the OIG's 10 percent deficiency benchmark. Additionally, the OIG found that of the eight transfer forms completed by a non-physician designee, none were co-signed by an appropriately privileged

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[91] VHA Directive 1094.

provider as required. This could result in the unsafe transfer of patients, the inability to accurately monitor and evaluate transfer data, and an incomplete medical record. The Director, Emergency Department stated that providers routinely completed a Care in the Community consult instead of the transfer form and acknowledged that the consult did not include all required documentation elements. Due to the small number of transfer forms that were completed by a non-physician designee, the OIG made no related recommendation.

Furthermore, VHA requires the Chief of Staff and ADPCS to ensure referring providers record specific elements in the transfer note, such as the transfer date and time, and patient's informed consent.[92] For the electronic health records reviewed, the OIG estimated that providers did not document the date and time on 33 (95% CI: 19.6 to 46.7) percent of transfer notes or patients' informed consent on 24 (95% CI: 12.5 to 36.9) percent of notes, both of which are statistically significantly above the OIG's 10 percent deficiency benchmark. These deficiencies could result in the unsafe transfer of patients, the inability to accurately monitor and evaluate transfer data, and an incomplete medical record. The Director, Emergency Department and Director, Intensive Care Unit both stated they believed the time of transfer referred to the actual transport time set up by support personnel and their documentation met the intent of the requirement. The Director, Emergency Department also reported believing that providers routinely obtained verbal informed consent from patients but competing clinical priorities may have hindered them from documenting this.

Recommendation 5

5. The Chief of Staff and Associate Director, Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure appropriately privileged providers complete all elements of the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note prior to patient transfers.

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[92] VHA Directive 1094.

Medical center concurred.

Target date for completion: December 31, 2022

Medical center response: The Chief of Staff and Associate Director, Patient Care Services (ADPCS) evaluated and determined no additional reasons for noncompliance. The Patient Flow Coordinator, who reports to the ADPCS through the Chief, Acute Care Nursing Service, began tracking all inter-facility transfers on April 1, 2021. Several fields were made mandatory on the Inter-facility Transfer Note completed by providers. These fields include transfer reason, diagnosis, level of care prior to transfer, stability for transfer, mode of transportation, information to be sent with the patient (complete medical record, x-rays, Advance Directive, current medication list, and list of allergies), consent to transfer, name of transferring physician and facility, name of receiving physician and facility, date and time of transfer, and non-VA medical services authorized were added to the Inter-facility Transfer Note used by providers. Fields were also made mandatory in the Emergency Department Disposition note including method of transport, date and time of transfer, receiving location, the reason for transfer, report given with the name of nurse information was provided to and at what date and time, phone number of receiving facility, accepting physician name, isolation/multi-drug resistant organism precautions, and pain score. Also included was chart copied and sent with the patient (options of records sent include: Emergency Room Encounter Report which includes problem list, allergies, code status, Advance Directive, current medications list, lab results, radiology report, history and physical, nursing notes, medications given, procedure notes, medical history, electrocardiogram, demographics sheet, health summary, and other which must be detailed in free text). Fields were also made mandatory in the Nursing Patient Transfer note including receiving location, the reason for movement, report given with the name of nurse information was provided to and at what date and time, transferring provider, accepting provider, isolation precautions, multi-drug resistant organisms, mental status, pain score, medication given, consent verification, and Administrative Officer of the Day notified. Also included was chart items sent with the patient (options of records sent include: Emergency Room Encounter Report which includes problem list, allergies, code status, and Advance Directive, current medications list, lab results, radiology report, history and physical, nursing notes, medications given, procedure notes, medical history, electrocardiogram, demographics sheet, health summary, and other which must be detailed in free text). Tracking includes verification of the following documentation: date and time of transfer, transferring unit, receiving facility, completion of the Inter-facility Transfer Note (VA Form 10-2649A) including the signature of an appropriately privileged provider, a co-signature for any Inter-facility Transfer Note initiated by a Physician Assistant, informed consent, notification given to transfer coordinator, beneficiary travel consult completed, mode of transportation, provider-to-provider communication, completion of Nursing Patient Transfer note/Nursing Disposition Note, documentation of nurse-to-nurse communication and that pertinent chart information (progress notes, test results, active medication lists, Advance Directive, and Discharge Summary as applicable) were sent with patients. The Patient Flow

Coordinator is also tracking any progress notes written by Physician Assistants and immediately notifies the corresponding service chief via email or by phone if the notes are not co-signed by a physician. The data is shared monthly with the Medicine, Mental Health, Long Term Care, and Emergency Department service chiefs and nurse managers via email. Action plans are requested from the service chiefs/nurse managers on any metric that falls below 90 percent. The data from tracking the documentation is reported monthly to the Patient Flow Committee by the Patient Flow Coordinator and any action plan is reported at that time. Medical Center Policy 11-078 Interfacility Transfers and Referral, which rescinded Medical Center Memorandum 11-78 Interfacility Transfers and Referral dated January 2019, has been updated and published in the Medical Center Document Control SharePoint. All Martinsburg VA Medical Center staff have 24-hour a day/7 day a week access to this SharePoint site.

Reporting Committee: The compliance for monitoring all inter-facility patient transfers is completed by appropriately privileged providers for all elements and will be reported to the Patient Flow Committee chaired by the Patient Flow Coordinator. The Patient Flow Committee reports quarterly to the Quality, Safety, and Values Council which the Chief of Staff and the Associate Director, Patient Care Services are members.

Frequency of Monitoring: Monthly monitoring of inter-facility transfers has been reported monthly by the Patient Flow Coordinator to the Patient Flow Committee since May 19, 2021. The numerator is the number of monthly inter-facility transfers with complete documentation of all Inter-facility Transfer Note elements. The denominator is the number of monthly inter-facility transfers. Monthly monitoring to ensure 90 percent monthly compliance for six consecutive months will be reported to the Patient Flow Committee.

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 [be sent] with the patient, including documentation of the patient's advance directive made prior to transfer, if any."[93] The OIG estimated that 67 (95% CI: 53.3 to 80.9) percent of electronic health records reviewed lacked evidence that staff sent an active medication list with the patient to the receiving facility, which is statistically significantly above the OIG's 10 percent deficiency benchmark. This could result in incorrect treatment decisions that potentially compromise patient safety. Additionally, for the 18 patients who had an advance directive, the OIG did not find evidence that staff sent a copy to the receiving facility with any of them during the transfer. As a result, there was no assurance that receiving facility staff could immediately determine patients' healthcare preferences. The Patient Flow Coordinator and Emergency Department/Nurse Infusion Clinic/Occupational Health Nurse Manager stated that staff routinely sent medication lists and advance directives with patients during inter-facility transfers but were

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[93] VHA Directive 1094.

unaware of the need to document these actions. Due to the small number of patients identified for the advance directive requirement, the OIG made no recommendation for this element.

Recommendation 6

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

Medical center concurred.

Target date for completion: December 31, 2022

Medical center response: The Chief of Staff and Associate Director, Patient Care Services (ADPCS) evaluated the reason for noncompliance and determined no additional reasons. Nursing Patient Transfer and Nursing Disposition Note templates were modified in February 2021 to ensure documentation of active medication lists being sent with the patient during inter-facility transfer. The Patient Flow Coordinator, who reports to the ADPCS through the Chief, Acute Care Nursing Service, has the responsibility of tracking this data monthly and reporting it monthly to the Patient Flow Committee. The Patient Flow Committee reports any noncompliance to the specific clinical service chief and requests an action plan. The Patient Flow Coordinator reports the noncompliance and associated action plan monthly to the Patient Flow Committee. If a trend in a service is identified, the Patient Flow Committee Chair (Patient Flow Coordinator) will follow up with the respective service chief/nurse manager on any issues in completing the action plan. Medical Center Policy 11-078 Interfacility Transfers and Referral, which rescinded Medical Center Memorandum 11-78 Inter-facility Transfers and Referral dated January 2019, has been updated and published in the Medical Center Document Control SharePoint. All Martinsburg VA Medical Center staff have 24-hour a day/7 day a week access to this SharePoint site.

Reporting Committee: The compliance for monitoring that active medication lists are completed and sent to the receiving facility during the inter-facility transfer will be reported to the Patient Flow Committee chaired by the Patient Flow Coordinator. The Patient Flow Committee reports quarterly to the Quality, Safety, and Values Council of which the Chief of Staff and the Associate Director, Patient Care Services are members.

Frequency of Monitoring: The numerator is the number of inter-facility transfers that include the active medication list being sent to the receiving facility. The denominator is the number of monthly inter-facility transfers. Monthly monitoring to ensure 90 percent monthly compliance for six consecutive months will be reported to the Patient Flow Committee.

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."[94] 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."[95] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior

- Implementation of an employee threat assessment team[96]

- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[97]

- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[98]

- Patient notification of an Order of Behavioral Restriction

- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[99]

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

[95] VHA Directive 2012-026.

[96] 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."

[97] 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."

[98] 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."

[99] 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.[100] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[101] 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 met some of the requirements for the management of disruptive and violent behavior. However, the OIG found deficiencies with Disruptive Behavior Committee meeting attendance and staff training.

VHA requires that the Chief of Staff and Nurse Executive (ADPCS) establish a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; a patient advocate; and representatives from the Prevention and Management of Disruptive Behavior program, VA police, patient safety and/or risk management, and the Union Safety Committee.[102] The committee or board is responsible for coordinating with clinicians, recommending amendments to 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.[103]

The OIG found that of the 12 Disruptive Behavior Committee meetings held from July 1, 2020, through June 30, 2021, a VA police representative did not attend 5 meetings (42 percent). The OIG also found that a patient advocate and administrative support staff did not attend 2 (17 percent) and 9 (75 percent) meetings, respectively. This could have resulted in a lack of knowledge and expertise when assessing patients' disruptive behavior and carrying out committee duties. The Disruptive Behavior Committee Chair explained that frequent administrative staff turnover, competing work demands for VA police, and lack of an alternate

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

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

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

[103] VHA Directive 2010-053.

patient advocate to attend meetings contributed to missed attendance. The chair further reported being unaware of the attendance requirement for an administrative representative.

Recommendation 7

7. The Chief of Staff and Associate Director, Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure all required members consistently attend Disruptive Behavior Committee meetings.

Medical center concurred.

Target date for completion: December 31, 2022

Medical center response: The Chief of Staff and Associate Director, Patient Care Services evaluated and determined no additional reasons for noncompliance. Attendance will be taken by the Disruptive Behavior Committee Chair. The Disruptive Behavior Committee Chair, who reports to Clinical Practice Council, is responsible for recording and monitoring Disruptive Behavior Committee meeting attendance for each core member: Chair (or Co-Chair), Patient Safety/Risk Management, Prevention and Management of Disruptive Behavior Program, clerical/administrative support staff, Veterans Experience Office, and Police.

Reporting Committee: The compliance for monitoring attendance of required core members of the Disruptive Behavior Committee chaired by a psychologist will be reported monthly to the Clinical Practice Council which the Chief of Staff and the Associate Director, Patient Care Services are members.

Frequency of Monitoring: Monthly monitoring to ensure 90 percent compliance for six consecutive months of attendance by the core members. The numerator is the number of times the core members of the Disruptive Behavior Committee attended the meetings and the denominator is the number of Disruptive Behavior Committee meetings held.

VHA requires the chair and members of the Employee Threat Assessment Team to complete specific workplace violence prevention program training.[104] The OIG found that the Employee Threat Assessment Team Chair had not completed three trainings, and one team member had not completed two. This could result in ineffective de-escalation of employees' disruptive behaviors in times of crisis. The Employee Threat Assessment Team Chair reported believing that completing other national training met the requirement for the chair and acknowledged a lack of oversight for the one noncompliant team member.

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

Recommendation 8

8. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that all Employee Threat Assessment Team members complete the required training.

Medical center concurred.

Target date for completion: July 31, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. Medical Center Director Standard Operating Procedure-0002 Employee Threat Assessment Team Case Management Process was updated to include the list of required Talent Management System courses members are to complete. The Safety Manager, as chair of the Employee Threat Assessment Team, will ensure any new member of the Employee Threat Assessment Team completes the required trainings for Intro to Employee Threat Assessment Team, Employee Threat Assessment Team Simulation, and Fundamentals of Threat Assessment for Disruptive Behavior Committees and Employee Threat Assessment Teams.

Reporting Committee: Employee Threat Assessment Team Talent Management System trainings compliance will be reported by the Safety Manager to Quality, Safety, and Value Council, which is chaired by the Medical Center Director.

Frequency of Monitoring: Monthly monitoring to ensure 100 percent compliance for six consecutive months of trainings by the team members. The numerator is the number of team members who have completed the trainings and the denominator is the total number of team members.

VHA requires that staff complete the prevention and management of disruptive behavior part 1 training on hire and "additional levels of PMDB [prevention and management of disruptive behavior] training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment."[105] The OIG found that 14 of 22 selected staff (64 percent) did not complete the required prevention and management of disruptive behavior part 2 training. This could result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Coordinator stated that, along with an infectious disease physician, they paused parts 2 and 3 training due to the rise in the local number of positive COVID-19 cases.

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

Recommendation 9

9. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[106]

Medical center concurred.

Target date for completion: December 31, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. Per the Memorandum dated March 2, 2022, from the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer regarding the Prevention and Management of Disruptive Behavior training requirements all staff who are above minimal risk, but less than high risk, will receive Part 2 moderate training rather than teaching Part 2 low due to restructuring of Prevention and Management of Disruptive Behavior national curriculum in 2019. Classes are being taught under strict controls due to COVID-19 Infection & Prevention Control standards for staff and subsequent patient safety. Prevention and Management of Disruptive Behavior standard requires two instructors regardless of class size with masking, good hand hygiene, eye protection, and social distancing whenever possible. Staff in high-risk areas as determined by the Workplace Behavior Risk Assessment with no prior training are prioritized and followed in cascading importance by staff most past due in those areas to least past due with the same prioritization in Long Term Care and Outpatient service areas. The Prevention and Management of Disruptive Behavior Train-the-Trainer was successfully completed November 15-19, 2021, and Martinsburg VA Medical Center has 16 facility trainers who can teach all levels/parts of PMDB. Classes were resumed on April 19, 2022, with eight students and two instructors per class with social distancing, masking, eye protection, and good hand hygiene as priorities. Thirty-nine staff were trained in Part 2 moderate and thirteen in Part 3 high by April 29, 2022. Classes are scheduled during the last week of May 2022 for 40 staff to complete Part 2 moderate and 8 for Part 3 high, and for June 2022 there are currently 16 scheduled for both Part 2 moderate and Part 3 high. July-September 2022 has enough classes already scheduled to allow 524 staff to complete their required levels of Prevention and Management of Disruptive Behavior training as long as the facility is in green (low) on the COVID-19 Preparedness Matrix, and we can train 16 students per class. One hundred students are scheduled to be trained by the end of the calendar year. Staff who have already completed Prevention and Management of Disruptive Behavior and who will be attending class will be assigned skills check one year from the date of class completion. The appropriate level of Prevention and Management of Disruptive Behavior training based on the Memorandum dated

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

March 2, 2022, from the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer has been added to the Martinsburg VA New Employee Orientation as of June 2002. Martinsburg VAMC's [VA Medical Center's] Prevention and Management of Disruptive Behavior Annual Training plan was submitted on April 29, 2022, and approved by the National Prevention and Management of Disruptive Behavior Director on May 5, 2022. The compliance for monitoring completion of required risk assessment trainings is reviewed and monitored by the Prevention and Management of Disruptive Behavior Coordinator. Risk levels are assigned by service area location Workplace Behavior Risk Assessments. Currently, staff can only register through the Prevention and Management of Disruptive Behavior Coordinator to ensure appropriate training levels are assigned. The Prevention and Management of Disruptive Behavior Coordinator provides the Talent Management System Administrators with rosters for entry after class. By the start of the next fiscal year (2023) the goal is to have the Talent Management System set up for staff to self-register again.

Reporting Committee: The compliance for monitoring completion of required risk assessment trainings is reviewed and monitored by the Prevention and Management of Disruptive Behavior Coordinator. The Prevention and Management of Disruptive Behavior Coordinator will report to the Quality, Safety, and Value Council which is chaired by the Medical Center Director.

Frequency of Monitoring: Monthly monitoring of compliance with Prevention and Management of Disruptive Behavior trainings until a 90 percent compliance rate is demonstrated for six consecutive months. The numerator is the number of staff who have completed the trainings (by risk level) and the denominator is the total number of staff required (per risk level).

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 nine recommendations on systemic 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 nine 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	- Executive leadership position stability and engagement - Budget and operations - Staffing - Employee satisfaction - Patient experience - Accreditation surveys and oversight inspections - Identified factors related to possible lapses in care and medical center response - VHA performance data (medical center) - VHA performance data (CLC)	Leaders properly identify adverse events as sentinel events when criteria are met and conduct institutional disclosures, as required.	None
COVID-19 Pandemic Readiness and Response	- Emergency preparedness - Supplies, equipment, and infrastructure - Staffing - Access to care - CLC patient care and operations - Staff feedback - Vaccine administration	The OIG 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.	

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

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• Appropriately privileged providers complete all elements of the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note prior to patient transfers. • Staff send patients' active medication lists to receiving facilities during inter-facility transfers.	• Staff monitor and evaluate all patient transfers.
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• All required members consistently attend Disruptive Behavior Committee meetings. • Employee Threat Assessment Team members complete the required training. • Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

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 Martinsburg VA Medical Center (613)
(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	$354,344,982	$384,560,261	$410,784,430
Number of:			
• Unique patients	36,883	37,852	37,093
• Outpatient visits	506,232	523,257	470,317
• Unique employees§	2,221	2,364	2,271
Type and number of operating beds:			
• Community living center	133	133	141
• Domiciliary	265	259	259
• Medicine	42	42	42
• Mental health	19	19	19
• Residential rehabilitation	8	8	8
• Surgery	6	6	6
Average daily census:			
• Community living center	105	178	130
• Domiciliary	233	265	121
• Medicine	28	29	28
• Mental health	14	17	16

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[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.

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019 †	Medical Center Data FY 2020‡
• Residential rehabilitation	7	10	4
• Surgery	3	3	2

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

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

*October 1, 2017, through September 30, 2018.
†October 1, 2018, through September 30, 2019.
‡October 1, 2019, through September 30, 2020.

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Cumberland, MD	613GA	4,506	2,017	Anesthesia Dermatology Eye Podiatry Rehabilitation physician	Electrocardiogram	Nutrition Pharmacy Social work Weight management
Hagerstown, MD	613GB	7,106	1,870	Anesthesia Dermatology Podiatry Rehabilitation physician	Electrocardiogram	Nutrition Pharmacy Weight management

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[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
Winchester, VA	613GC	7,375	2,190	Anesthesia Dermatology Eye Podiatry Rehabilitation physician	Electrocardiogram	Nutrition Pharmacy Social work Weight management
Franklin, WV	613GD	454	18	Dermatology	Electrocardiogram	Nutrition Pharmacy
Petersburg, WV	613GE	2,026	648	Anesthesia Dermatology	Electrocardiogram	Nutrition Pharmacy
Harrisonburg, VA	613GF	5,987	1,146	Dermatology	Electrocardiogram	Nutrition Pharmacy Weight management
Frederick, MD	613GG	5,068	2,339	Anesthesia Dermatology Podiatry	Electrocardiogram	Nutrition Pharmacy Social work Weight management

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

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

Appendix D: Patient Aligned Care Team Compass Metrics
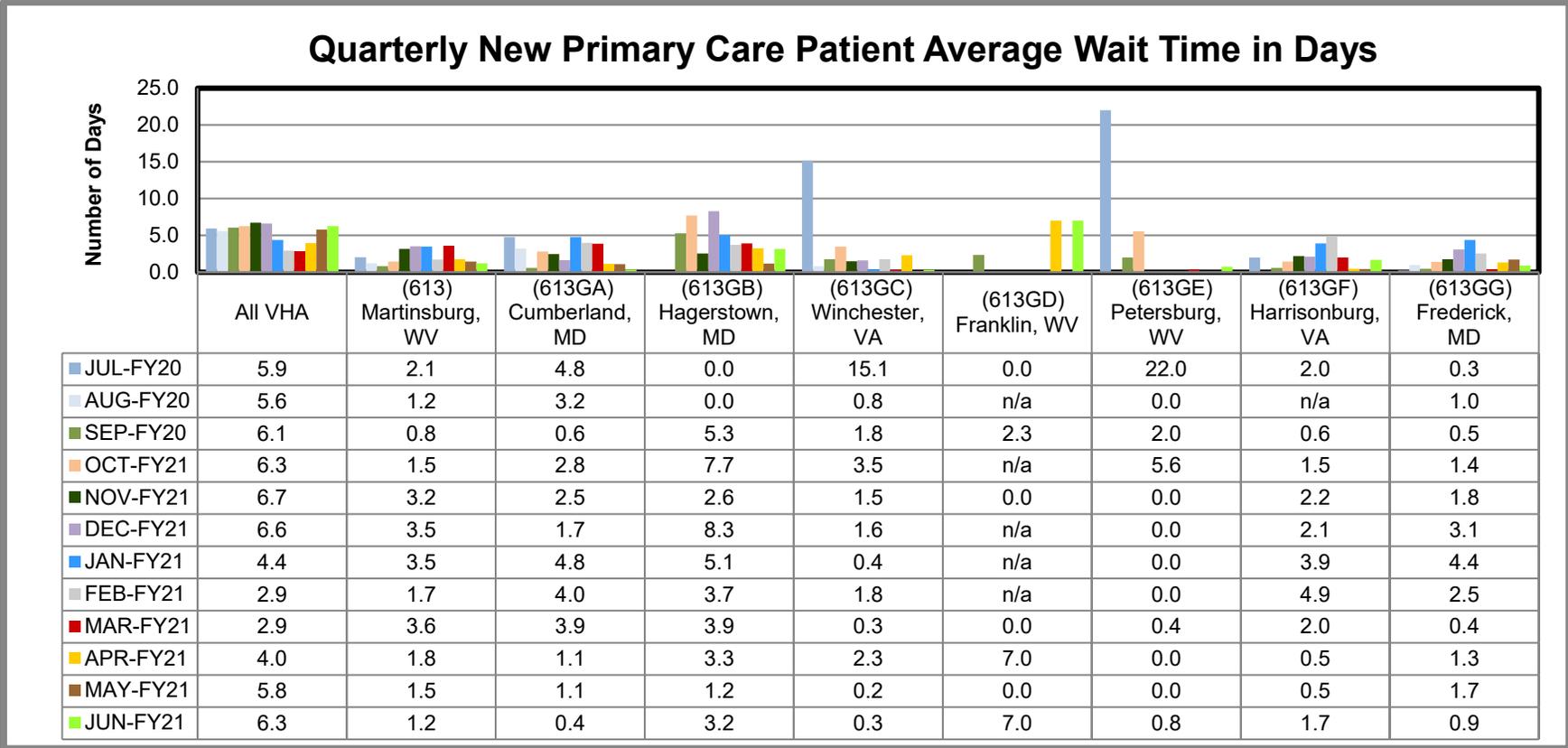
Quarterly New Primary Care Patient Average Wait Time in Days

	All VHA	(613) Martinsburg, WV	(613GA) Cumberland, MD	(613GB) Hagerstown, MD	(613GC) Winchester, VA	(613GD) Franklin, WV	(613GE) Petersburg, WV	(613GF) Harrisonburg, VA	(613GG) Frederick, MD
■ JUL-FY20	5.9	2.1	4.8	0.0	15.1	0.0	22.0	2.0	0.3
■ AUG-FY20	5.6	1.2	3.2	0.0	0.8	n/a	0.0	n/a	1.0
■ SEP-FY20	6.1	0.8	0.6	5.3	1.8	2.3	2.0	0.6	0.5
■ OCT-FY21	6.3	1.5	2.8	7.7	3.5	n/a	5.6	1.5	1.4
■ NOV-FY21	6.7	3.2	2.5	2.6	1.5	0.0	0.0	2.2	1.8
■ DEC-FY21	6.6	3.5	1.7	8.3	1.6	n/a	0.0	2.1	3.1
■ JAN-FY21	4.4	3.5	4.8	5.1	0.4	n/a	0.0	3.9	4.4
■ FEB-FY21	2.9	1.7	4.0	3.7	1.8	n/a	0.0	4.9	2.5
■ MAR-FY21	2.9	3.6	3.9	3.9	0.3	0.0	0.4	2.0	0.4
■ APR-FY21	4.0	1.8	1.1	3.3	2.3	7.0	0.0	0.5	1.3
■ MAY-FY21	5.8	1.5	1.1	1.2	0.2	0.0	0.0	0.5	1.7
■ JUN-FY21	6.3	1.2	0.4	3.2	0.3	7.0	0.8	1.7	0.9

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
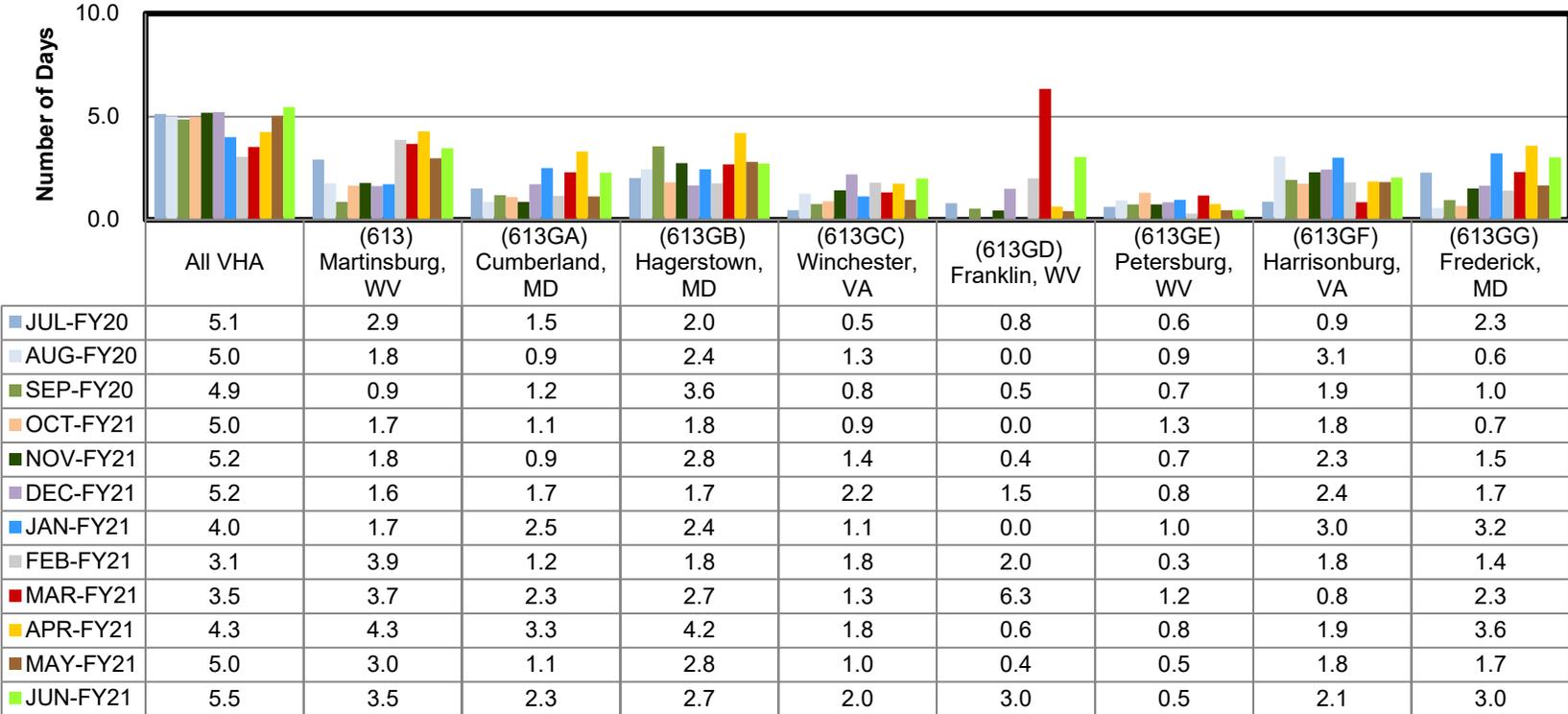
	All VHA	(613) Martinsburg, WV	(613GA) Cumberland, MD	(613GB) Hagerstown, MD	(613GC) Winchester, VA	(613GD) Franklin, WV	(613GE) Petersburg, WV	(613GF) Harrisonburg, VA	(613GG) Frederick, MD
JUL-FY20	5.1	2.9	1.5	2.0	0.5	0.8	0.6	0.9	2.3
AUG-FY20	5.0	1.8	0.9	2.4	1.3	0.0	0.9	3.1	0.6
SEP-FY20	4.9	0.9	1.2	3.6	0.8	0.5	0.7	1.9	1.0
OCT-FY21	5.0	1.7	1.1	1.8	0.9	0.0	1.3	1.8	0.7
NOV-FY21	5.2	1.8	0.9	2.8	1.4	0.4	0.7	2.3	1.5
DEC-FY21	5.2	1.6	1.7	1.7	2.2	1.5	0.8	2.4	1.7
JAN-FY21	4.0	1.7	2.5	2.4	1.1	0.0	1.0	3.0	3.2
FEB-FY21	3.1	3.9	1.2	1.8	1.8	2.0	0.3	1.8	1.4
MAR-FY21	3.5	3.7	2.3	2.7	1.3	6.3	1.2	0.8	2.3
APR-FY21	4.3	4.3	3.3	4.2	1.8	0.6	0.8	1.9	3.6
MAY-FY21	5.0	3.0	1.1	2.8	1.0	0.4	0.5	1.8	1.7
JUN-FY21	5.5	3.5	2.3	2.7	2.0	3.0	0.5	2.1	3.0

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019. (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	Care coordination (PCMH)	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care (SC) providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All-cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH survey)	A higher value is better than a lower value

Measure	Definition	Desired Direction
Tobacco & cessation (SMG90_1)	HEDIS outpatient performance measure composite related to tobacco screening and cessation strategies	A lower value is better than a higher value

Source: VHA Support Service Center.

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

Measure	Definition
ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
AntiPsy (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
AntiPsy (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Cath (LS)	Long-stay measure: of residents who have had an indwelling catheter in the last 7 days.
DischCom (SS)	Short-stay measure: percentage of short-stay residents who were successfully discharged to the community.
Falls (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
HRPU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
ImprvFnctn (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
MovmntWorsnd (LS)	Long-stay measure: percentage of residents whose need for help with activities of daily living has increased.
NewPU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
NumED (LS)	Long-stay measure: Number of all-cause outpatient emergency department visits.
NumHosp (LS)	Long-stay measure: Number of unplanned inpatient admissions or all-cause outpatient observation stays at an acute care or critical access hospital.
OutptED (SS)	Short-stay measure: percent of short-stay residents who have had an outpatient emergency department (ED) visit.

Measure	Definition
Rehosp (SS)	Short-stay measure: percent of residents who were re-hospitalized after a nursing home admission.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 22, 2022

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

Subj: Comprehensive Healthcare Inspection of the Martinsburg VA Medical Center in 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 Martinsburg VA Medical Center in West Virginia.

2. I have reviewed the Medical Center Director's response and concur with the corrective actions outlined. Actions for recommendation #1 are completed and we look forward to submitting for closure with the initial status update.

3. Furthermore, recommendations # 2, 3, 4, 5, 6, 7, 8, and 9 will remain open and in progress.

4. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VISN 5 Quality Management Officer.

(Original signed by:)

Robert M. Walton, FACHE

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 22, 2022

From: Director, Martinsburg VA Medical Center (613/00)

Subj: Comprehensive Healthcare Inspection of the Martinsburg VA Medical Center in West Virginia

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

1. Thank you for the opportunity to review the draft report of the OIG Comprehensive Healthcare Inspection Program Review of the Martinsburg VA Medical Center, Martinsburg, West Virginia. I have reviewed the document and concur with the findings and recommendations.

2. The facility Chief of Quality Management will be available for additional information or assistance.

3. I thank you for the opportunity to continue strengthening our high-quality health care activities.

(Original signed by:)

Kenneth W. Allensworth, FACHE
Medical Center Director/CEO

OIG Contact and Staff Acknowledgments

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