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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

CHIP Report | 23-00012-136 | April 11, 2024

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

Source: [*https://www.va.gov/martinsburg-health-care/locations/*](https://www.va.gov/martinsburg-health-care/locations/) (*accessed June 26, 2023*).

Abbreviations

ADPCS	Associate Director, Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	Licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
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 multiple 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 the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the Martinsburg VA Medical Center during the week of March 27, 2023. 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 and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued three recommendations to the Chief of Staff and Associate Director in the Medical Staff Privileging and Environment of Care areas of review. 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 leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results

are detailed throughout the report, and the recommendations are summarized in appendix A on page 18.

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 C and D, pages 21–22, 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.

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

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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 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 they can make informed decisions 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]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[4]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

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

[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): 13, https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. 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] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Martinsburg VA Medical Center includes multiple outpatient clinics in Maryland, Virginia, and West Virginia. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review during the week of March 27, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[5] The OIG's last comprehensive healthcare inspection of the Martinsburg VA Medical Center occurred in August 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in February 2023.

[6] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this medical center's leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and medical center leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Director; Chief of Staff; Associate Director, Patient Care Services (ADPCS); and Associate Director. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive leadership team had worked together for over one year. The most tenured leader was the ADPCS, who had been in the position since February 2017.

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[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[8] Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $484,478,260 had increased by approximately 9 percent compared to the previous year's budget of $446,367,822.[10] The Associate Director indicated using the funds to open an expanded intensive care unit, while the ADPCS highlighted hiring more nurses. The Chief of Staff stated that a significant portion of the increase provided funding for care in the community.[11]

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] 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 facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[13] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The facility's scores matched VHA's for FYs 2020 through 2022. The Director and ADPCS attributed the scores to leaders' efforts to promote a just culture and transparency at all levels of the organization.[14]

[10] Veterans Health Administration (VHA) Support Service Center.

[11] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed September 21, 2023, https://www.va.gov/communitycare/.

[12] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

[13] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

[14] "Just culture is an environment that balances the need for an open and honest reporting environment with the end goal of organizational and behavioral improvement. While the organization has a duty and responsibility to employees (and ultimately to Veterans), all employees are held responsible for the quality of their choices." VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Martinsburg VA Medical Center	3.8	3.9	3.9

Source: VA All Employee Survey (accessed November 15, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to 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.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

Patients' satisfaction with their inpatient and primary care experiences declined in FY 2022, but satisfaction with specialty care improved. The ADPCS said the Veteran Experience Officer collected patient experience data and shared it weekly with senior leaders, allowing them to make more informed decisions to improve patients' experiences. The Associate Director further reported that in 2021, the Veteran Experience Officer coordinated with nurse leaders in some departments to increase opportunities for leaders to interact with staff and patients.

[15] "Patient Experiences Survey Results," VHA Support Service Center.

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	66.9	69.7	72.3	68.9	69.5
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?*†	82.5	86.3	81.9	84.9	81.7	84.2
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	86.4	83.3	82.1	83.1	85.6

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

**The response average is the percent of "Definitely yes" responses.*

†*The response average is the percent of "Very satisfied" and "Satisfied" responses.*

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[16] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[17] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[16] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[17] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[18]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[19] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's 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."[20] Lastly, a large-scale disclosure is "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."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[22]

The OIG requested a list of sentinel events and institutional disclosures that occurred during FY 2022 and reviewed the information staff provided. The Associate Director explained that the medical center's focus on patient safety included patient safety and risk management staff providing regular updates to senior leaders every two weeks. The Chief of Staff discussed working closely with risk management staff to determine which sentinel events require an institutional disclosure, while the ADPCS added the Director made the final decision on whether to conduct an institutional disclosure.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[18] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

[19] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

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

[21] VHA Directive 1004.08.

[22] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[23] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[25]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[26] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[27]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[28] 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."[29] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[30]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed one death that occurred within 24 hours of inpatient admission during FY 2022. The team requested a list of patient suicides that occurred within seven days of discharge from an inpatient mental health unit during FY 2022, and medical center staff reported no patients met those criteria.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

[24] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[25] VHA Directive 1100.16.

[26] VHA Handbook 1050.01; VHA Directive 1050.01(1).

[27] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[28] 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. VHA Directive 1190.

[29] VHA Directive 1190.

[30] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[31] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[32]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[33] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[34]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation (OPPE) to ensure the continuous delivery of quality care.[35]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[36] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

[31] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[37]

The OIG interviewed key managers and selected and reviewed the privileging folders of 22 LIPs who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to recommend continued privileges, in part, on OPPE activities such as direct observation, clinical discussions, and chart reviews.[38] The OIG found that some LIPs' privileging folders lacked evidence the service chiefs recommended continued privileges, in part, on OPPE activities. This may have resulted in LIPs continuing to deliver care without thorough reviews of their practices, which could negatively affect patient care and safety. The Medical Staff Coordinator cited staffing issues and competing priorities as reasons service chiefs recommended privileges prior to completion of OPPE activities.

Recommendation 1

1. The Chief of Staff ensures service chiefs recommend continued privileges based on Ongoing Professional Practice Evaluation activities.

[37] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[38] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: A new electronic process has been implemented by the Medical Staff Office (MSO). Individual practitioner folders were created for each service and the newly standardized Ongoing Professional Practice Evaluations (OPPEs) were uploaded for that practitioner. This new process enables the MSO staff to track, audit, and present at Executive Council of the Medical Staff-Credentials Committee (ECMS-CC) during the credentialing and re-credentialing periods. Prior to submitting the practitioner's packet (packet consists of Curriculum Vitae (CV), Release of Information, Malpractice Claims Form, Advanced Cardiac Life Support/Basic Life Support (ACLS/BLS), Drug Enforcement Administration (DEA), License(s), References, and Previous Privileges/Scope of Practice) for review, the service chief will review OPPE data for the past two years, sign off (wet signature) on their new Scope of Practice/Privileges then sign in an electronic credentialing and privileging software attesting that the OPPEs have been reviewed and that there are no concerns to continuing the practitioner's privileging. The Credentialing & Privileging Analyst will do the monthly monitoring and the Credentialing & Privileging Manager will be reporting the results to ECMS-CC and then to Quality and Patient Safety Council until 90 percent compliance is maintained for six consecutive months. The numerator will be the number of licensed independent practitioners' (LIPs) OPPEs with evidence that the service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities. The denominator will be the number of LIPs' OPPEs that service chiefs reviewed.

VHA also requires an executive committee of the medical staff to recommend continuation of privileges based on OPPE results.[39] The OIG found that for some LIPs' OPPEs, the Executive Committee of the Medical Staff/Credentials Committee recommended continuation of privileges but could not consistently provide evidence recommendations were based on OPPE results. Consequently, the committee may have recommended privileges with insufficient evidence to support its decision. The Medical Staff Coordinator reported service chiefs' lack of oversight resulted in incomplete OPPE results submitted to the Executive Committee of the Medical Staff/Credentials Committee.

Recommendation 2

2. The Chief of Staff ensures the Executive Committee of the Medical Staff/Credentials Committee recommends continuation of licensed independent practitioners' privileges based on Ongoing Professional Practice Evaluation results.

[39] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: A new electronic process has been implemented by the Medical Staff Office (MSO). Individual practitioner folders were created for each service and the newly standardized OPPEs were uploaded for that practitioner. This new process enables the MSO staff to track, audit, and present at Executive Council of the Medical Staff-Credentials Committee (ECMS-CC) during the credentialing and re-credentialing periods. The service chief presents the licensed independent practitioner's (LIP) packet (packet consists of Curriculum Vitae (CV), Release of Information, Malpractice Claims Form, Advanced Cardiac Life Support/Basic Life Support (ACLS/BLS), Drug Enforcement Administration (DEA), License(s), References, and Previous Privileges/Scope of Practice) at ECMS-CC for committee consideration. ECMS-CC supports and endorses the service chief's recommendation for renewal of privileges. The ECMS-CC recommendation and the LIP's packet is sent to the Chief of Staff (COS) for approval. The COS recommendation and LIP's packet are sent to the Medical Center Director for final approval of privileges. The Credentialing & Privileging Analyst will do the monthly monitoring and the Credentialing & Privileging Manager will be reporting the results to ECMS-CC and then to Quality and Patient Safety Council until 90 percent compliance is maintained for six consecutive months. The numerator will be the number of LIPs' OPPEs that reflect evidence that the ECMS-CC reviewed and considered OPPE results in their re-privileging determinations. The denominator will be the number of LIPS' OPPEs that the ECMS-CC reviewed.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[40] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[41]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[42]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected six patient care areas:

- Community living center (Tranquility House)
- Emergency Department
- Inpatient mental health unit (6A)
- Intensive care unit
- Medical/surgical unit
- Primary care clinic (CPC 1)

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[40] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[41] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[42] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

Environment of Care Findings and Recommendations

VHA requires staff to check inventory in clean and sterile storerooms and take necessary corrective actions for expired or outdated items.[43] In two of the six patient care areas inspected, the OIG found expired medical supplies.[44] The use of expired medical supplies may pose safety risks to patients. The Chief, Supply Chain reported staff inconsistently completed monthly inventory inspections in supply storage areas due to increased workloads resulting from staffing shortages.

Recommendation 3

3. The Associate Director ensures staff check inventory in clean and sterile storerooms and remove expired or outdated items.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: Supply Chain staff will check inventory weekly in clean and sterile storerooms and take necessary corrective actions for cleanliness, expired, and damaged items. Any expired or damaged items are immediately removed by Supply Chain staff. This check will be documented on a weekly sign-off sheet posted in the storeroom, to include the initials of the staff who performed the review, and the date review was completed. If a particular storeroom contains multiple inventory points, a separate log sheet will be maintained for each inventory point and posted in the storeroom. The Chief Supply Chain Officer will monitor the sign-off sheet documentation and will report this data to the Environment of Care Council monthly, which is chaired by the Associate Director, until 90 percent compliance is maintained for six consecutive months. The numerator is the number of completed storeroom sign-off sheets demonstrating compliance with checking inventory and removing expired or outdated items. The denominator is the total number of storeroom sign-off sheets completed during weekly inspections for six consecutive months.

[43] VHA Directive 1761.

[44] The OIG found deficiencies in the intensive care and medical/surgical units.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[45] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[46] The suicide rate for veterans was higher than for nonveteran adults during 2020.[47] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[48]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[49] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[50]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[51]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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[45] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[46] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed March 10, 2022.

[47] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[48] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[49] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[50] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[51] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

The OIG made no recommendations.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided three recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Chief of Staff and Associate Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs recommend continued privileges based on Ongoing Professional Practice Evaluation activities. • The Executive Committee of the Medical Staff/Credentials Committee recommends continuation of licensed independent practitioners' privileges based on Ongoing Professional Practice Evaluation results.
Environment of Care	• Staff check inventory in clean and sterile storerooms and remove expired or outdated items.
Mental Health: Suicide Prevention Initiatives	• None

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, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$410,784,430	$446,367,822	$484,478,260
Number of: • Unique patients	37,093	40,420	39,583
• Outpatient visits	470,317	510,960	497,080
• Unique employees§	1,712	1,724	1,673
Type and number of operating beds: • Community living center	141	141	141
• Domiciliary	259	259	182
• Medicine	42	42	42
• Mental health	19	19	19
• Residential psychiatry	8	8	8
• Surgery	6	6	6
Average daily census: • Community living center	118	96	92
• Domiciliary	120	34	59
• Medicine	28	29	29
• Mental health	16	11	10
• Residential psychiatry	4	0	6

[1] VHA medical facilities are classified according to a 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." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census, cont.: • Surgery	2	1	2

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

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

**October 1, 2019, through September 30, 2020.*
†October 1, 2020, through September 30, 2021.
‡October 1, 2021, through September 30, 2022.
§Unique employees involved in direct medical care (cost center 8200).

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 21, 2024

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 (54CH01)

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

1. I have reviewed and concur with the Office of Inspector General's (OIG) draft report entitled – Comprehensive Healthcare Inspection of the Martinsburg VA Medical Center in West Virginia.
2. I concur with the Medical Center Director's response and corrective actions. Recommendations # 1, 2, and 3 will remain open and in progress.
3. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VISN 5 Quality Management Officer.

(Original signed by:)

Robert M. Walton, FACHE

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 13, 2024

From: Director, Martinsburg VA Medical Center (613)

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

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

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

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

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

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Karla Kisiel, BSN, RN, Team Leader Christine El-Zoghbi, PhD Elisa Gomez, RN, MSN Robert Ordonez, MPA Simonette Reyes, BSN, RN
Other Contributors	Melinda Alegria, AuD, CCC-A Elizabeth Bullock Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Jarvis Yu, MS

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