VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts

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Figure 1. *VA Boston Healthcare System in Massachusetts.*

Source: https://vaww.va.gov/directory/guide/ (accessed January 21, 2021).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Boston Healthcare System, which includes three campuses—Brockton, Jamaica Plain, and West Roxbury—and five outpatient clinics in Massachusetts. 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 review of the VA Boston Healthcare System during the week of January 25, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this healthcare system and other Veterans Health Administration (VHA)

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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)."

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

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual review, the healthcare system's leadership team consisted of the System Director, Deputy Director, Chief of Staff, and Nurse Executive. 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 Improvement Committee, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the healthcare system's leaders had worked together for over six years. The Nurse Executive, who was permanently assigned in June 2000, was the most tenured leader. The Deputy Director, who was assigned in August 2014, was the newest member of the leadership team. The Chief of Staff and System Director had served in their positions since June 2003 and September 2013, respectively.

The OIG reviewed survey results and concluded that scores related to the System Director, Deputy Director, Chief of Staff, and Nurse Executive were generally better than those for VHA and the healthcare system. Selected patient experience survey scores generally reflected similar or higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

The inspection team also reviewed accreditation agency findings and did not identify any substantial organizational risk factors. However, the OIG identified deficiencies with institutional disclosures of adverse events.

The VA Office of Operational Analytics and Reporting adopted 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."[2] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one

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[2] "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.)

way to understand the similarities and differences between the top and bottom performers within VHA.[3]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures. Leaders also had an understanding of Community Living Center SAIL measures.[4] In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The healthcare system complied with requirements for a committee responsible for quality, safety, and value oversight functions; the Systems Redesign and Improvement Program; and the Surgical Work Group. However, the OIG identified a weakness with protected peer review processes.[5]

Medication Management

The healthcare system generally complied with many of the indicators of expected performance, including the availability of staff to receive remdesivir shipments, provision of required testing prior to remdesivir administration, and reporting of adverse events. However, the OIG identified deficiencies with patient or caregiver education prior to remdesivir administration.

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

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

[5] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A 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.

Mental Health

The healthcare system generally complied with requirements for the completion of suicide safety plans and staff training. However, the OIG noted opportunities for improvement with the initiation of the Columbia-Suicide Severity Rating Scale.

Care Coordination

The OIG identified deficiencies with the existence of an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, completion of the VA *Inter-Facility Transfer Form* or facility-defined equivalent note, transmission of patients' active medication lists and advance directives to receiving facilities, and nurse-to-nurse communication between facilities.[6]

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued eight recommendations for improvement to the System Director, Chief of Staff, and Nurse Executive. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for system leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

Comments

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

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

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

Contents

Purpose and Scope

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

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

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual 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 (QSV)

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)."

5. Medication management (targeting remdesivir use)

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7. Care coordination (spotlighting inter-facility transfers)

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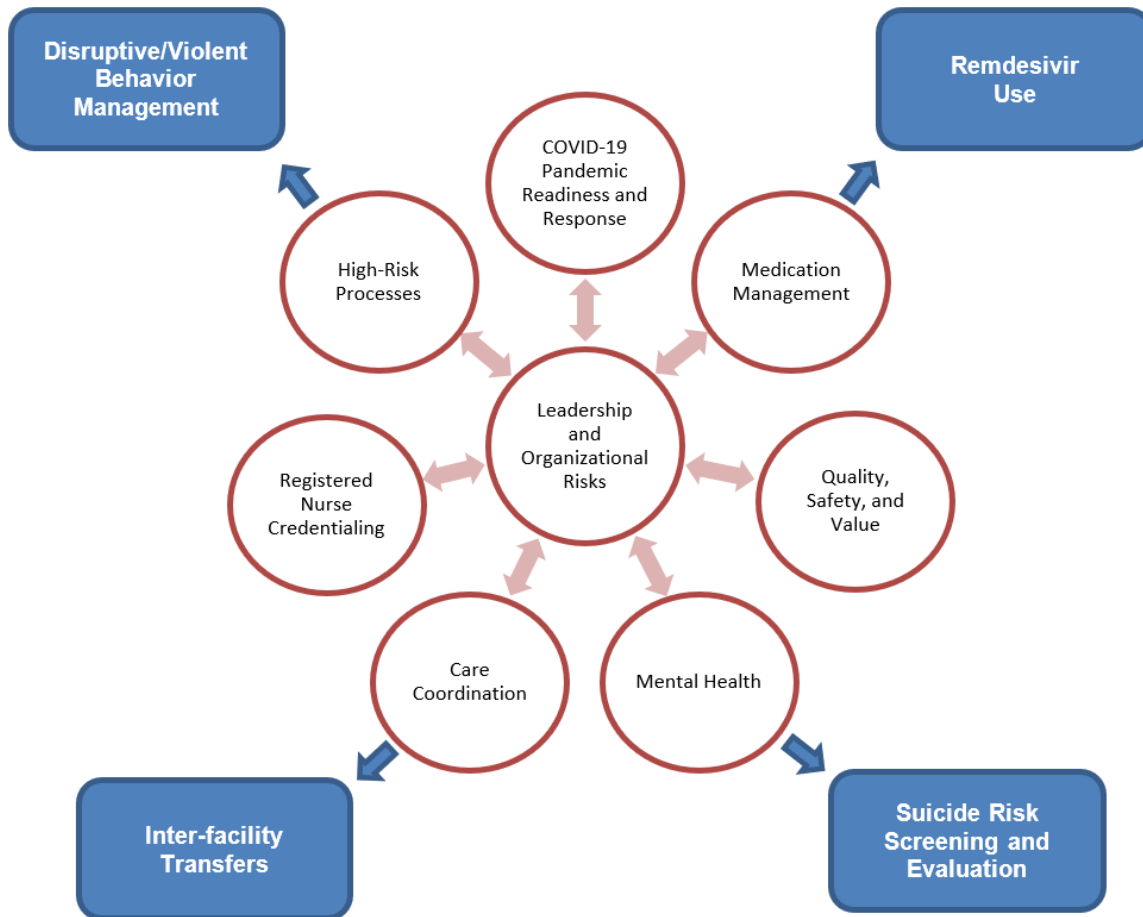

Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

The VA Boston Healthcare System includes the Brockton, Jamaica Plain, and West Roxbury campuses, and five outpatient clinics in Massachusetts. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from April 14, 2018, through January 29, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

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

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the healthcare system completes corrective actions. The System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that 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 prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in January 2021.

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

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership position stability and engagement

2. Budget and operations

3. Staffing

4. Employee satisfaction

5. Patient experience

6. Accreditation surveys and oversight inspections

7. Identified factors related to possible lapses in care and the healthcare system response

8. VHA performance data (healthcare system)

9. VHA performance data (community living center (CLC))[10]

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the System Director, Deputy Director, Chief of Staff, and Nurse Executive.[11] The Chief of Staff and Nurse Executive oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

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

[11] The Associate Director, Quality Management provided the OIG with a system leadership organizational chart signed by the System Director on January 26, 2021.

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                          │      Director       │
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Chief of Staff	Nurse Executive	Deputy Director	Associate Director Quality Management
Associate Chief of Staff Associate Chief of Staff/Education Associate Chief of Staff/Research & Development Chief, Anesthesia Chief, Dental Chief, Emergency Services Chief, Geriatrics & Extended Care Chief, Medicine Chief, Mental Health Chief, Neurology Chief, Pain Management & Rehabilitation Chief, Pathology & Lab Chief, Primary Care Chief, Psychology Chief, Radiation Therapy Chief, Radiology Chief, Social Work Chief, Spinal Cord Injuries Chief, Surgery Deputy Chief of Staff	Associate Chief Nurse Associate Chief Nursing Service, Clinical Operations Associate Chief Nursing Service, Long Term Care/Spinal Cord Injury Associate Chief Nursing Service, Mental Health, Urgent Care Associate Chief Nursing Service, Quality Management/Medical Information Systems Deputy Nurse Executive	Assistant Director, Brockton Assistant Director, Jamaica Plain Chief, Business Office Chiefs, Canteen Chief, Chaplain Chief, Clinical Engineering Chief, Engineering Chief, Environmental Management Service Chief, Fiscal Chief, Food & Nutrition Chief, Human Resources Chief, Logistics Chief, Pharmacy Chief, Police Chief, Prosthetics Chief, Transportation Chief, Voluntary and Recreation	Accreditation Innovation Patient Safety Risk Management Systems Redesign

Figure 3. *Healthcare system organizational chart.*

Source: VA Boston Healthcare System (received January 26, 2021).

At the time of the OIG inspection, the executive team had worked together for over six years (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
System Director	September 8, 2013
Deputy Director	August 10, 2014
Chief of Staff	June 1, 2003
Nurse Executive	June 4, 2000

Source: VA Boston Healthcare System Strategic Business Partner (Human Resources Specialist) (received January 25 and 27, 2021).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the System Director, Deputy Director, Chief of Staff, and Nurse Executive regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. Leaders also had an understanding of CLC SAIL measures. In individual interviews, the executive leadership team members were able to speak in depth 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.

The System 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, including the Administrative Executive Board and Medical Executive Committee.[12] Leaders monitored patient safety and care through the Quality Improvement Committee, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Governing Board (see figure 4).

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[12] In April 2021, the Associate Director, Quality Management reported to the OIG that the system's committee reporting structure was being reorganized as committee policies were updated to committee charters.
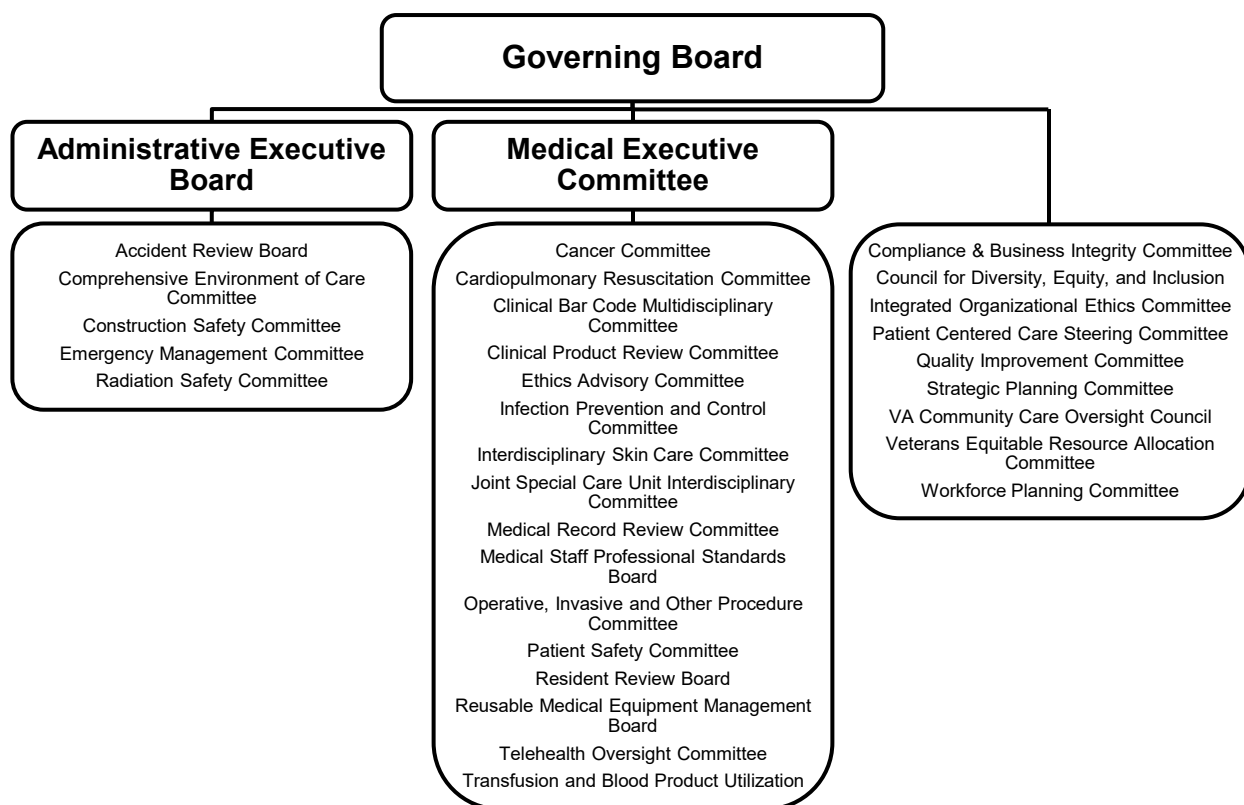
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                        ┌─────────────────────────┐
                        │     Governing Board      │
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Governing Board

Administrative Executive Board

Medical Executive Committee

Administrative Executive Board:
- Accident Review Board
- Comprehensive Environment of Care Committee
- Construction Safety Committee
- Emergency Management Committee
- Radiation Safety Committee

Medical Executive Committee:
- Cancer Committee
- Cardiopulmonary Resuscitation Committee
- Clinical Bar Code Multidisciplinary Committee
- Clinical Product Review Committee
- Ethics Advisory Committee
- Infection Prevention and Control Committee
- Interdisciplinary Skin Care Committee
- Joint Special Care Unit Interdisciplinary Committee
- Medical Record Review Committee
- Medical Staff Professional Standards Board
- Operative, Invasive and Other Procedure Committee
- Patient Safety Committee
- Resident Review Board
- Reusable Medical Equipment Management Board
- Telehealth Oversight Committee
- Transfusion and Blood Product Utilization

- Compliance & Business Integrity Committee
- Council for Diversity, Equity, and Inclusion
- Integrated Organizational Ethics Committee
- Patient Centered Care Steering Committee
- Quality Improvement Committee
- Strategic Planning Committee
- VA Community Care Oversight Council
- Veterans Equitable Resource Allocation Committee
- Workforce Planning Committee

Figure 4. Healthcare system committee reporting structure.
Source: VA Boston Healthcare System (received January 26, 2021).

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $940,493,929 had increased over 3.7 percent compared to the previous year's budget of $906,549,687.[13] When asked about the effect of this change on the healthcare system's operations, the System Director indicated the FY 2020 budget was the best in recent years.

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.[14] 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

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[13] VHA Support Service Center.

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

within each medical facility.[15] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[16]

Table 2 provides the top system-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[17] The executive leaders confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection. The System Director reported that the shortages result from VA classification and pay. The Deputy Director reported that the VA Boston Healthcare System cannot compete with the private sector and that, to increase staff pay, the Deputy Director wrote and presented a white paper to the Office of Personnel Management. The Deputy Director also reported that the white paper highlighted reasons why those working at the VA Boston Healthcare System should receive a higher locality pay than federal employees working in other areas such as Vermont. While the Office of Personnel Management declined the proposal, the Deputy Director reported being asked to work with 11 federal agencies in Boston to further develop the proposal. Additionally, the executive leaders reported that the VISN 1 Human Resource Modernization efforts made it difficult to hire and complete employee actions. However, the Nurse Executive shared that nursing school partnerships and the "Other Side of the Bed" program have increased the qualified applicant pool.[18]

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Medical Instrument Technician	1. General Engineering
2. Health Aid and Technician	2. Electrician
3. Pharmacy Technician	3. Food Service Worker
4. Dental Officer	4. Air Conditioning Equipment Mechanic
5. Diagnostic Radiologic Technologist	5. Budget Analysis

Source: VA OIG.

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[15] 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.

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

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

[18] The "Other Side of the Bed" program allows end-of-first-year medical students to engage in intensive patient care experiences and gain exposure to nurse roles, experiences, and environments before their first medical school clinical rotation.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[19] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[20] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[21] Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the healthcare system averages for the selected survey leadership questions were higher than the VHA averages.[22] The OIG noted the same trend for all members of the executive leadership team.

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	System Director Average	Chief of Staff Average	Nurse Executive Average	Deputy Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.5	77.6	93.8	80.0	84.4	96.7
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.4	3.8	4.6	4.2	4.2	4.7

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[19] "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.)

[20] "AES Survey History."

[21] Ratings are based on responses by employees who report to or are aligned under the System Director, Deputy Director, Chief of Staff, and Nurse Executive.

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	System Director Average	Chief of Staff Average	Nurse Executive Average	Deputy Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	4.0	4.7	4.1	4.3	4.8
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.9	4.7	4.4	4.3	4.7

Source: VA All Employee Survey (accessed December 21, 2020).

*The Servant Leader Index is a summary 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.[23] The healthcare system averages for the selected survey questions were better than the VHA averages. Scores related to each member of the executive team were generally better than those for VHA and the healthcare system.

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	System Director Average	Chief of Staff Average	Nurse Executive Average	Deputy 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	4.0	4.9	4.2	4.2	4.5

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[23] Ratings are based on responses by employees who report to or are aligned under the System Director, Deputy Director, Chief of Staff, and Nurse Executive.

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	System Director Average	Chief of Staff Average	Nurse Executive Average	Deputy Director Average
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)	3.7	3.9	4.6	4.2	4.2	4.6
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	1.2	1.4	1.0	0.6	0.3

Source: VA All Employee Survey (accessed December 21, 2020).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[24] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[25] The Director shared that system-wide harassment trainings and listening sessions are provided.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The healthcare system and executive leader averages for the selected survey questions were better than the VHA averages. Leaders appeared to maintain an environment where staff felt respected and safe and discrimination was not tolerated. System leaders attributed their scores to having difficult conversations when needed, being transparent, leading by example, and communicating often with staff.

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[24] "Stand Up to Stop Harassment Now!" Department of Veterans Affairs, accessed December 8, 2020, https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/. Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

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

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	System Director Average	Chief of Staff Average	Nurse Executive Average	Deputy Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.0	4.6	4.1	4.1	4.8
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.0	4.2	4.7	4.3	4.5	5.0
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.6	4.2	4.1	4.7

Source: VA All Employee Survey (accessed December 21, 2020).

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the healthcare system.[26] For this system, the overall patient satisfaction survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

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[26] Ratings are based on responses by patients who received care at this healthcare system.

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

Questions	Scoring	VHA Average	System 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	77.0
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	89.5
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	93.0

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[27] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). The results for male respondents were consistently more favorable than the corresponding VHA averages. The results for female respondents were generally more positive than female VHA patients nationally. System leaders reported awareness of gender disparities, and the System Director stated there was room for improvement.

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[27] "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*		Healthcare System	
		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	77.3	69.9
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	87.9	77.6
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	89.1	92.4

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

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

The healthcare system averages are based on 516–523 male and 24–25 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
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	60.7	51.3

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
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	68.9	59.2
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	80.8	75.5

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

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

The healthcare system averages are based on 465–1,482 male and 28–74 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
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	63.6	72.1
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	72.1	57.3
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	81.1	67.2

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

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

The healthcare system averages are based on 523–1,659 male and 21 or 59 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.[28] Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint

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[28] "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 other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization."

Commission (TJC).[29] At the time of the OIG review, the system had closed all recommendations for improvement issued since the previous CHIP site visit conducted in April 2018.

The OIG team also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[30] Additional results included the Long Term Care Institute's inspection of the system's CLC and the Paralyzed Veterans of America's inspection of the system's spinal cord injury/disease unit and related services.[31]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the VA Boston Healthcare System, Massachusetts*, Report No. 17-05570-06, October 23, 2018)	April 2018	7	0
OIG (*Review of Delays in Clinical Consult Processing at VA Boston Healthcare System, Massachusetts*, Report No. 17-05504-107, April 11, 2019)	June 2018	0	–

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[29] 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."

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

[31] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings." The Paralyzed Veterans of America inspection took place September 11, 2018, and July 30, 2019. This veterans service organization review does not result in accreditation status.

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC Behavioral Health Care Accreditation	May 2018	6	0

Source: OIG and TJC (TJC inspection/survey results received from an Accreditation Specialist on January 25, 2021).

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

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

Table 11 lists the reported patient safety events from April 14, 2018 (the prior OIG CHIP site visit), through January 25, 2021.[32]

**Table 11. Summary of Selected
Organizational Risk Factors
(April 14, 2018, through January 25, 2021)**

Factor	Number of Occurrences
Sentinel Events	20
Institutional Disclosures	5
Large-Scale Disclosures	0

*Source: VA Boston Healthcare System Risk Manager and
Patient Safety Officer (received January 26, 2021).*

The Risk Manager and Patient Safety Officer reported 20 sentinel events from April 14, 2018, through January 25, 2021. However, the OIG noted that healthcare system staff did not conduct institutional disclosures for 17 of 20 applicable patient-specific sentinel events (see Leadership and Organizational Risks Findings and Recommendations).

Veterans Health Administration Performance Data for the Healthcare System

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[33] Despite noted limitations for identifying all areas

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[32] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The VA Boston Healthcare System is a highest complexity (1a) 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."

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

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of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[34]

Figure 5 illustrates the healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows VA Boston Healthcare System's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of rating (of) specialty care (SC) provider, care transition, rating (of) hospital, and hospital wide readmission (RSRR-HWR)). 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 and adjusted length of stay (LOS)).[35]
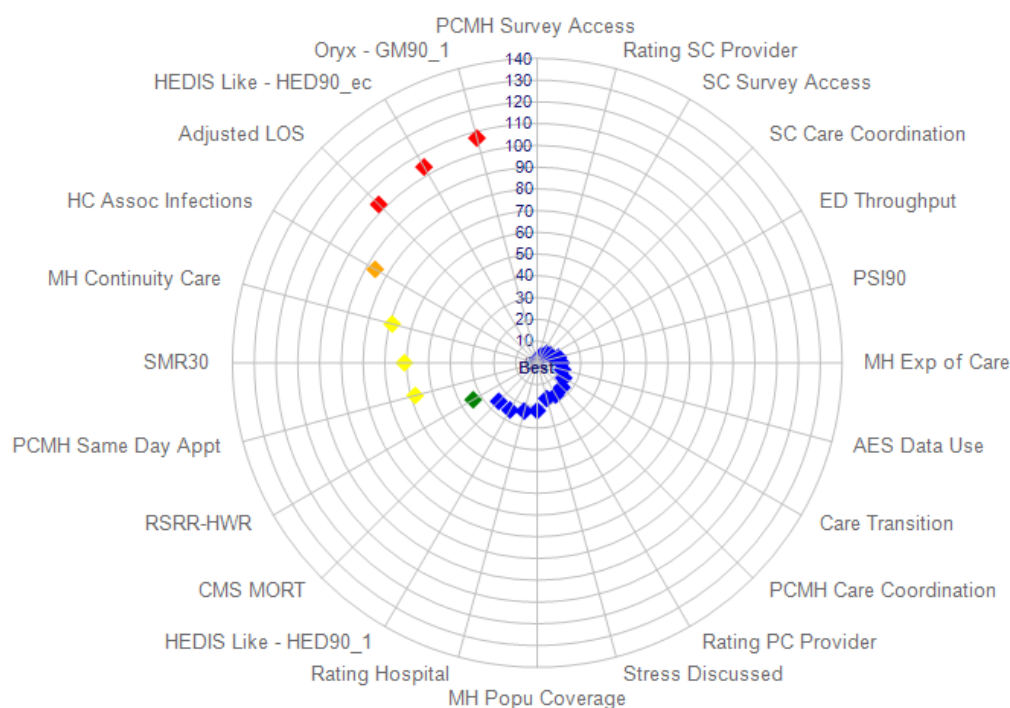

Figure 5. VA Boston Healthcare System quality of care and efficiency metric rankings for FY 2020 quarter 3 (as of June 30, 2020).

Source: VHA Support Service Center.

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

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[34] "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.)

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

Veterans Health Administration Performance Data for the Community Living Center

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

Figure 6 illustrates the healthcare system's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the VA Boston Healthcare System's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of new or worse pressure ulcer (PU)–short-stay (SS) and urinary tract infections (UTI)–long-stay (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, discharged to community (SS), help with activities of daily living (ADL) (LS), and moderate-severe pain (LS)).[38]

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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,* July 16, 2021.

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

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

Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile
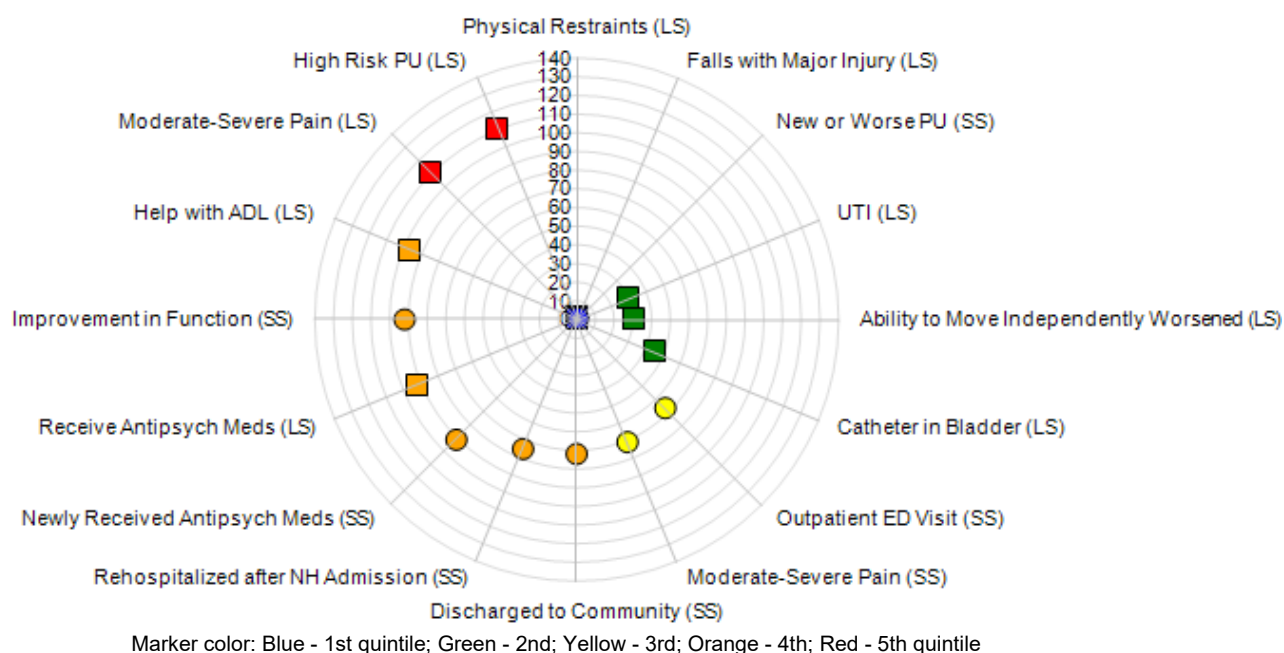
Figure 6. VA Boston Healthcare System CLC quality measure rankings for FY 2020 quarter 3 (as of June 30, 2020).

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

The system's executive leadership team appeared stable and had worked together for over six years at the time of the OIG's review. The executive leaders discussed interim strategies to address clinical and nonclinical occupational shortages.

Selected employee satisfaction survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected and discrimination was not tolerated. Patient experience survey data indicated satisfaction with the care provided. Further, the OIG found that selected survey results for male respondents were consistently more favorable than those for male VHA patients nationally. Results for female respondents were generally more positive than female VHA patients nationally.

In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. Executive leaders were also knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models. However, the OIG noted deficiencies with the system's institutional disclosure process.

VHA requires that a VA medical center director or designee is responsible for ensuring an institutional disclosure is performed when an adverse event occurs during patient care that "resulted in, or is reasonably expected to result in, death or serious injury."[39] VHA policy states that "serious injury may include significant or permanent disability, injury that leads to prolonged hospitalization, injury requiring life-sustaining intervention, or intervention to prevent impairment or damage, including, for example sentinel events as defined by The Joint Commission."[40] The OIG reviewed the system-reported sentinel events that occurred from April 14, 2018, through January 25, 2021. The OIG found that the system did not provide institutional disclosures for 17 of 20 applicable patient-specific sentinel events. The failure to perform an institutional disclosure can erode VA's core values and reduce patients' trust in the organization.[41] The Chief of Staff stated that institutional disclosures were assigned to different people—the assumption was that assigned individuals would complete the institutional disclosures that "fell through the cracks."

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures disclosure of adverse events that require an institutional disclosure.

Healthcare system concurred.

Target date for completion: February 28, 2022

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. All adverse events occurring during patient care that resulted in, or are reasonably expected to result in, death or serious injury are monitored and tracked by the Patient Safety Manager through the Joint Patient Safety Reporting System. Adverse events requiring institutional disclosures are identified by the Patient Safety Manager and reviewed with the Risk Manager and the Chief of Staff, Deputy Chief of Staff, or Associate Chief of Staff. Institutional disclosures are coordinated by the Patient Safety Manager and the Risk Manager. The numerator will be the number of completed institutional disclosures and the denominator will be all adverse events requiring institutional disclosure. Monitoring will continue until compliance is sustained at 90 percent for six consecutive months. The Risk Manager will email a monthly report of compliance to the System Director.

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[39] VHA Directive 1004.08.

[40] VHA Directive 1004.08.

[41] VHA Directive 1004.08.

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.[42] 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.[43]

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."[44] "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."[45]

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

- Emergency preparedness

- Supplies, equipment, and infrastructure

- Staffing

- Access to care

- CLC patient care and operations

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

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

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[42] "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.

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

[44] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision 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."

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[46] 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.[47] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), 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."[48]

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

- Review of aggregated QSV data

- Recommendation and implementation of improvement actions

- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[49] 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."[50] 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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[46] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

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

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

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

[50] VHA Directive 1026.01.

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[51] 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."[52] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[53] 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[54]

- Completion of final reviews within 120 calendar days

- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[55]

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

Finally, the OIG assessed the healthcare system's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[56] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select

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[51] 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."

[52] VHA Directive 1190.

[53] VHA Directive 1190.

[54] VHA Directive 1190.

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

[56] "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, https://vaww.nso.med.va.gov/apps/VASQIP/Pages/Default.aspx. (This is an internal VA website not publicly accessible.)

specialty programs."[57] The healthcare system's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery

- Assignment and duties of a surgical quality nurse (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[58]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[59]

Quality, Safety, and Value Findings and Recommendations

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

VHA requires the System Director to ensure that the Peer Review Committee completes the final review of each case within 120 calendar days from the determination that a peer review is needed, or the System Director approves a written extension request.[60] From January 1 through December 31, 2020, the OIG found that three peer review cases were not completed within 120 days and had no approved written extension signed by the System Director. This likely prevented timely improvements in patient care at the system. The risk managers acknowledged that the three peer review cases were inadvertently omitted from the extension request.

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

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

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

[60] VHA Directive 1190.

Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and ensures the Peer Review Committee completes a final review of each case within 120 calendar days from the determination that a peer review is needed or approves a written extension request.

Healthcare system concurred.

Target date for completion: February 28, 2022

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. All protected peer reviews not finalized within 120 calendar days from the determination that a peer review is needed will be identified by the Risk Manager who will request a written extension from the System Director. Monitoring will be completed by the Risk Manager who will track the number of monthly protected peer reviews, the number of protected peer reviews not finalized within 120 days, and the number of protected peer reviews with and without written extensions signed by the System Director. The numerator is the number of protected peer reviews not finalized within 120 days that have a written extension signed by the System Director and the denominator is the number of protected peer reviews not finalized within 120 days. Monitoring will continue until compliance is sustained at 90 percent for six consecutive months. The Risk Manager will provide a monthly email to the System Director reporting compliance.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[61] 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."[62]

VA requires all RNs to hold at least one active, unencumbered license.[63] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[64] 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.[65] 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.[66]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 81 RNs hired from January 1 through December 20, 2020. The OIG determined whether

- the RNs were free from potentially disqualifying licensure actions, or

- the Chief, Human Resources Management Service or Regional Counsel determined that the RNs met VA licensure requirements.

The OIG also reviewed the credentialing files for 30 of the 81 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

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[61] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

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

[63] VA Directive 2012-030. "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."

[64] 38 U.S.C. § 7402.

[65] VHA Directive 2012-030.

[66] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[67] 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.[68]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[69] 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.[70]

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."[71] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[72]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of 16 patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments

- Medication orders used proper name

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[67] 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.

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

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

[70] 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.*

[71] 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.

[72] 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)[73]

  o Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[74]

- Patient/caregiver education provided

- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The healthcare system generally complied with many of the indicators of expected performance, including the availability of staff to receive remdesivir shipments, provision of required testing prior to remdesivir administration, and reporting of adverse events. However, the OIG identified deficiencies with patient or caregiver education prior to remdesivir administration.

At the time of the review, under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the "Fact Sheet for Patients and Parents/Caregivers," inform patients or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[75] For the 16 electronic health records reviewed, the OIG found that clinical staff did not

- provide the "Fact Sheet for Patients and Parents/Caregivers" to any of the patients or caregivers before administering remdesivir,

- inform 88 percent of patients or caregivers that remdesivir was not an FDA-approved medication,

- inform 31 percent of patients or caregivers of the option to refuse remdesivir,

- inform 63 percent of patients or caregivers of the potential risks and benefits, and

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[73] "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."

[74] "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.

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

- inform any of the patients or caregivers of alternatives to receiving remdesivir.[76]

This could have resulted in the patient or caregiver lacking information needed to make a fully informed decision to receive the medication. The Chief, Infectious Disease reported believing that providers communicated all required patient or caregiver education prior to remdesivir administration and was not aware of the requirement to document each patient education element.

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

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

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

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[78] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[79] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[80]

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

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

- Completion of suicide safety plans by required staff

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

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

- relevant documents;

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[78] "Preventing Suicide," Centers for Disease Control and Prevention, accessed December 9, 2020, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

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

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

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

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

- the electronic health records of 47 randomly selected patients who were seen in the emergency department/urgent care center from December 1, 2019, through August 31, 2020; and

- staff training records.

Mental Health Findings and Recommendations

The OIG found the healthcare system generally complied with requirements for the completion of suicide safety plans and staff training. However, the OIG noted opportunities for improvement with the initiation of the Columbia-Suicide Severity Rating Scale.

VHA requires that all veterans who present to emergency departments and urgent care centers are screened for suicide risk using the Columbia-Suicide Severity Rating Scale.[83] The OIG estimated that 40 percent of patients were not screened during their emergency department or urgent care center visit.[84] Failure to screen for suicide risk could result in missed opportunities to identify veterans at risk for suicide and implement suicide safety plans. The Chief, Mental Health stated the Columbia-Suicide Severity Rating Scale tool sustained several national changes that caused ambiguity regarding the requirements and delayed system-wide implementation and staff training.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that emergency department and urgent care center staff screen patients for suicide risk using the Columbia-Suicide Severity Rating Scale.

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[83] Office of Mental Health and Suicide Prevention, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting*, updated June 18, 2020; "VA Suicide Risk Identification Strategy, Technical Assistance Call," Department of Veterans Affairs, November 14, 2019.

[84] The OIG estimated that 95 percent of the time, the true compliance rate is between 44.9 and 73.3 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: February 28, 2022

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Columbia-Suicide Severity Rating Scale (C-SSRS) was embedded into the Nursing Triage Note that is completed with all Emergency Department (ED)/Urgent Care Center (UCC) visits. The Associate Chief Nursing Service (ACNS), Quality Management/Medical Information Systems (QM/MIS) created an educational PowerPoint regarding accurate completion of the C-SSRS that was provided to the Chief, Emergency Services and the nurse managers of the ED and UCCs for use in educating ED/UCC providers and nursing staff in June 2021. The ACNS, QM/MIS will monitor the total number of C-SSRSs completed during ED/UCC visits (numerator) and 100 percent of the ED/UCC visits (denominator). Monitoring will continue until compliance is sustained at 90 percent for six consecutive months. The Associate Director, Quality Management will provide a monthly email report to the Chief of Staff.

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.[85]

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."[86] 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.[87]

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

- Existence of a facility policy for inter-facility transfers

- Monitoring and evaluation of inter-facility transfers

- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer

- Transmission of patient's active medication list and advance directive to the receiving facility

- Communication between nurses at sending and receiving facilities

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 58 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG identified deficiencies with all the requirements listed above.

VHA requires the System Director to implement a written policy to ensure "the safe, appropriate, orderly, and timely transfer of patients."[88] The OIG found no evidence of an inter-facility transfer policy. Failure to maintain a current inter-facility transfer policy could result in lack of

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

[86] VHA Directive 1094.

[87] 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.

[88] VHA Directive 1094.

coordination between facilities to provide seamless care for patients through the transfer process. The Chief of Staff reported believing system efforts met requirements by referring to VHA Directive 1094, as VHA encourages referral to VHA policy rather than creating local policies.

Recommendation 4

4. The System Director evaluates and determines any additional reasons for noncompliance and establishes a written policy to ensure the safe, appropriate, orderly, and timely transfer of patients.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. VISN 1 is currently developing a VISN Inter-Facility Transfer (IFT) policy. The VISN Flow Coordinator will notify the VA Boston Healthcare System Associate Director, Quality Management of the finalization of the VISN IFT policy. The Associate Director, Quality Management will develop, route for concurrence, and finalize a local policy for the System Director's signature. The System Director will sign the approved local policy and the Associate Director, Quality Management will publish the local policy on the system intranet website and communicate the local policy update to all staff via email.

VHA requires that the Chief of Staff and Associate Director of Patient Care Services (Nurse Executive) ensure "all transfers are monitored and evaluated as part of VHA's Quality Management Program."[89] The OIG found no evidence of monitoring and evaluation of patient transfers from January 1 through December 31, 2020. This could inhibit the healthcare system's ongoing performance improvement activities. The Chief of Staff acknowledged lacking awareness of the requirement.

Recommendation 5

5. The Chief of Staff and Nurse Executive evaluate and determine any additional reasons for noncompliance and ensure staff monitor and evaluate patient transfers.

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[89] VHA Directive 1094.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff and Nurse Executive evaluated and determined no additional reasons for noncompliance. The ACNS, QM/MIS created an audit tool in June 2021 to capture documentation of the following required elements within the IFT documentation: receiving licensed independent provider (LIP) accepted the patient for transfer, sending LIP completed the IFT note in full, and sending and receiving LIPs were both identified by name and title. The audit tool will also capture the referring LIPs documentation of: the date and time of transfer, mode of transportation, equipment needed, patient's (or legally responsible person acting on patient's behalf) informed consent prior to transfer, medical and/or behavioral stability of the patient for transfer, appropriate level of care required during transportation, details of the need for care, and the proposed level of care after transfer. Finally, the audit tool will capture documented transmission of the patient's active medication list, including any medications given to patient prior to transfer, and advance directive to the receiving facility as well as nurse-to-nurse communication. The numerator is the number of records containing documentation of all required elements listed above and the denominator is the total number of ED, UCC, and emergent inpatient IFTs. The nurse managers of the ED and UCCs and the Transfer Coordinator, who report through the ACNS, Clinical Operations, will monitor, evaluate and take corrective action on the IFT documentation monthly and report the results from the audits monthly to the ACNS, QM/MIS until 90 percent or greater compliance is achieved for six consecutive months. The ACNS, QM/MIS will email the performance data monthly to the Chief of Staff and Nurse Executive and will add this metric to the Nursing Service Quality Improvement Plan for ongoing monitoring.

VHA requires the Chief of Staff and Associate Director of Patient Services (Nurse Executive) to ensure appropriately privileged providers include the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record prior to inter-facility transfers.[90] The OIG estimated that 98 percent of the electronic health records reviewed lacked the VA *Inter-Facility Transfer Form* or an equivalent note.[91] Additionally, the OIG estimated that none of the transfer documentation included all required elements necessary to ensure patient safety, such as date and time transfer occurred, the patient's informed consent, medical stability for transfer, mode of transportation, and identification of the receiving physician. These deficiencies could result in the unsafe transfer of patients, the inability to monitor and evaluate transfer data, and an incomplete medical record. The Chief of Staff reported the system used a paper version of the

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[90] VHA Directive 1094.

[91] The OIG estimated that 95 percent of the time, the true compliance rate is between 0.0 and 5.7 percent, which is statistically significantly below the 90 percent benchmark.

VA *Inter-Facility Transfer Form,* which was sent with the patient and not scanned into the electronic health record.

Recommendation 6

6. The Chief of Staff and Nurse Executive evaluate and determine any additional reasons for noncompliance and ensure appropriately privileged providers complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note, that includes all required elements, in the electronic health record prior to patient transfers.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff and Nurse Executive evaluated and determined no additional reasons for noncompliance. The ACNS, QM/MIS created a templated ED/UCC IFT Provider Note and ED/UCC IFT Nursing Note to be entered into the electronic health record for each IFT. Similarly, templated notes will be created for the emergent inpatient IFT. The ACNS, QM/MIS created and delivered an educational PowerPoint to the Chief of Emergency Services and nurse managers of the ED and UCCs, who report through the ACNS, Clinical Operations, in June 2021. Similarly, education will be provided to the Chief of Staff, Deputy Chief of Staff, and Nurse Executive on the new templated inpatient IFT notes. The ACNS, QM/MIS created an audit tool in June 2021 to capture documentation of the following required elements within the IFT documentation: receiving LIP accepted the patient for transfer, sending LIP completed the IFT note in full, and sending and receiving LIPs were both identified by name and title. The audit tool will also capture the referring LIPs documentation of: the date and time of transfer, mode of transportation, equipment needed, patient's (or legally responsible person acting on patient's behalf) informed consent prior to transfer, medical and/or behavioral stability of the patient for transfer, appropriate level of care required during transportation, details of the need for care, and the proposed level of care after transfer. Finally, the audit tool will capture documented transmission of the patient's active medication list, including any medications given to patient prior to transfer, and advance directive to the receiving facility as well as nurse-to-nurse communication. The numerator is the number of records containing documentation of all required elements and the denominator is the total number of ED, UCC and Emergent inpatient IFTs. The nurse managers of the ED and UCCs and the Transfer Coordinator, who report through the ACNS, Clinical Operations, will collect, evaluate and take corrective action on the data monthly and report the results from the audits monthly to the ACNS, QM/MIS until 90 percent or greater compliance is achieved for six consecutive months. The ACNS, QM/MIS will email the performance data monthly to the Chief of Staff and Nurse Executive and will add this metric to the Nursing Service Quality Improvement Plan for ongoing monitoring.

VHA requires that the Chief of Staff and Associate Director of Patient Care Services (Nurse Executive) 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."[92] The OIG estimated that 98 percent of electronic health records lacked evidence that staff sent an active medication list to the receiving facility.[93] Additionally, the OIG determined that all 27 applicable records lacked evidence that staff sent the advance directive to the receiving facility.[94] This could result in incorrect treatment decisions that potentially compromise patient safety and lack of assurance that receiving facility staff could determine patient preferences regarding their health care at transfer.[95] The Chief of Staff stated the system used a paper version of the VA *Inter-Facility Transfer Form* and that the paper documentation, with the required information, was sent with the patient and not scanned into the electronic health record. Due to the small number of patients identified for the advance directive requirement, the OIG made no recommendation.

Recommendation 7

7. The Chief of Staff and Nurse Executive evaluate and determine any additional reasons for noncompliance and make certain that staff send patients' active medication lists to the receiving facility during inter-facility transfers.

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[92] VHA Directive 1094.

[93] The OIG estimated that 95 percent of the time, the true compliance rate is between 0.0 and 5.8 percent, which is statistically significantly below the 90 percent benchmark.

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

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

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff and Nurse Executive evaluated and determined no additional reasons for noncompliance. The ED/UCC IFT Nursing Note specifically prompts the nurse to document that the patients' active medication list was transmitted to the receiving facility during the IFT. A similar template will be deployed to capture this same element for all emergent inpatient inter-facility transfers. The numerator is the number of records containing documented transmission of the patient's active medication list to the receiving facility and the denominator is the total number of ED, UCC and emergent inpatient inter-facility transfers. The nurse managers of the ED and UCCs and the Transfer Coordinator, who report through the ACNS, Clinical Operations, will collect, evaluate and take corrective action on the data monthly and report the results from the audits monthly to the ACNS, QM/MIS until 90 percent or greater compliance is achieved for six consecutive months. The ACNS, QM/MIS will email the performance data monthly to the Chief of Staff and Nurse Executive and will add this metric to the Nursing Service Quality Improvement Plan for ongoing monitoring.

VHA requires that the Chief of Staff and Associate Director of Patient Care Services (Nurse Executive) ensure nurse-to-nurse communication occurs during the inter-facility transfer process, as it is essential and allows for questions and answers from staff at both sending and receiving facilities.[96] Based on the electronic health records reviewed, the OIG estimated that nurse-to-nurse communication did not occur during 86 percent of patient transfers.[97] This could result in staff at the receiving facility lacking the information needed to care for patients. The Nurse Executive reported that the system did not have a templated nursing note for inter-facility transfers, which would provide evidence that communication occurred.

Recommendation 8

8. The Chief of Staff and Nurse Executive evaluate and determine any additional reasons for noncompliance and ensure that nurse-to-nurse communication occurs as part of the inter-facility transfer process.

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[96] VHA Directive 1094.

[97] The OIG estimated that 95 percent of the time, the true compliance rate is between 5.6 and 23.2 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: February 28, 2022

Healthcare system response: The Chief of Staff and Nurse Executive evaluated and determined no additional reasons for noncompliance. The ED/UCC Inter-Facility Nursing Note prompts the nurse to document the nurse-to-nurse communication with the receiving facility. A similarly templated nursing note will be deployed to capture the nurse-to-nurse communication with the receiving facility for all inpatient IFTs. The numerator is the number of records containing documentation of nurse-to-nurse communication with the receiving facility and the denominator is the total number of ED, UCC and emergent inpatient IFTs. The nurse managers of the ED and UCCs and the Transfer Coordinator, who report through the ACNS, Clinical Operations, will collect, evaluate and take corrective action on the data monthly and report the results from the audits monthly to the ACNS, QM/MIS until 90 percent or greater compliance is achieved for six consecutive months. The ACNS, QM/MIS will email the performance data monthly to the Chief of Staff and Nurse Executive and will add this metric to the Nursing Service Quality Improvement Plan for ongoing monitoring.

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."[98] 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."[99] 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[100]

- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[101]

- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[102]

- Patient notification of an Order of Behavioral Restriction

- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[103]

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

[99] VHA Directive 2012-026.

[100] 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."

[101] 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."

[102] 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."

[103] 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 also 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.[104] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[105] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

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

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

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

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of eight clinical and administrative areas and provided eight recommendations on systemic issues that may adversely affect patients. While the OIG's recommendations are not a comprehensive assessment of the caliber of services delivered at this healthcare system, they illuminate areas of concern and provide a road map for improvement. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines eight OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the System Director, Chief of Staff, and Nurse Executive. 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 healthcare system response - VHA performance data (healthcare system) - VHA performance data (CLC)	The system discloses adverse events that require an institutional disclosure.	None
COVID-19 Pandemic Readiness and Response	- Emergency preparedness - Supplies, equipment, and infrastructure - Staffing - Access to care - CLC patient care and operations - Staff feedback	The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• None	• The Peer Review Committee completes a final review of each case within 120 calendar days, or the System Director approves a written extension request.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• Emergency department and urgent care center staff screen patients for suicide risk using the Columbia-Suicide Severity Rating Scale.	• 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 the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note, that includes all required elements, in the electronic health record prior to patient transfers. • Staff send patients' active medication lists to the receiving facility during inter-facility transfers. • Nurse-to-nurse communication occurs as part of the inter-facility transfer process.	• The system establishes a written policy to ensure the safe, appropriate, orderly, and timely transfer of patients. • Staff monitor and evaluate 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	• None

Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 1.[1]

Table B.1. Profile for VA Boston Healthcare System (523)
(October 1, 2017, through September 30, 2020)

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019	Healthcare System Data FY 2020‡
Total medical care budget	$821,479,269	$906,549,687	$940,493,929
Number of:			
• Unique patients	61,114	59,180	55,065
• Outpatient visits	721,918	738,459	669,848
• Unique employees§	3,598	3,714	3,763
Type and number of operating beds:			
• Community living center	112	87	87
• Domiciliary	98	98	98
• Medicine	103	103	103
• Mental health	126	126	111
• Neurology	6	6	6
• Rehabilitation medicine	5	5	5
• Residential rehabilitation	33	33	33
• Spinal cord	64	64	64
• Surgery	45	45	45
Average daily census:			
• Community living center	82	86	67
• Domiciliary	72	65	39
• Medicine	74	73	69
• Mental health	98	102	87
• Neurology	3	3	2

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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.) An affiliated healthcare system is associated with a medical residency program. VHA facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high volume, high risk patients, most complex clinical programs, and large research and teaching programs."

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019	Healthcare System Data FY 2020‡
• Rehabilitation medicine	3	3	2
• Residential rehabilitation	20	25	20
• Spinal cord	37	45	41
• Surgery	26	26	19

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

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

*October 1, 2017, through September 30, 2018.
 October 1, 2018, through September 30, 2019.
‡October 1, 2019, through September 30, 2020.
§Unique employees involved in direct medical care (cost center 8200).

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Lowell, MA	523BY	4,444	2,493	Anesthesia Eye Gastroenterology General surgery Infectious disease Nephrology Neurology Orthopedics Podiatry Pulmonary/ Respiratory disease Rheumatology Urology	EKG Radiology	Nutrition Pharmacy Prosthetics 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
Lowell, MA, cont.				Vascular		
Boston, MA	523BZ	2,768	5,704	Podiatry Rheumatology	–	Nutrition Pharmacy Weight management
Framingham, MA	523GA	2,181	494	–	–	Nutrition
Quincy, MA	523GC	2,083	–	–	–	–
Plymouth, MA	523GD	2,575	7	–	–	Nutrition Weight management

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

	VHA All	(523) Jamaica Plain, MA	(523A4) West Roxbury, MA	(523A5) Brockton, MA	(523BY) Lowell, MA	(523BZ) Causeway, MA	(523GA) Framingham, MA	(523GC) Quincy, MA	(523GD) Plymouth, MA
JAN-FY19	8.3	7.2	11.0	4.0	2.2	7.4	1.9	3.4	14.7
FEB-FY19	8.1	8.2	7.5	2.2	0.4	5.9	3.1	6.6	22.2
MAR-FY19	6.9	8.2	6.5	2.6	0.7	4.6	2.8	10.2	12.0
APR-FY19	3.6	10.0	2.0	4.6	2.9	11.0	n/a	17.0	8.9
MAY-FY19	4.0	18.0	2.1	18.6	6.6	8.8	4.7	9.0	1.4
JUN-FY19	4.9	22.4	7.3	20.4	12.4	13.0	5.8	22.5	2.4
JUL-FY19	5.9	10.8	7.4	26.8	8.8	n/a	4.5	18.2	4.7
AUG-FY19	5.6	20.4	13.8	18.5	5.8	12.0	1.3	19.0	3.7
SEP-FY19	6.1	6.0	18.3	10.7	1.8	14.5	0.0	24.5	4.1
OCT-FY20	6.3	6.3	6.6	8.0	1.3	14.0	0.0	24.4	9.4
NOV-FY20	6.7	15.4	12.0	1.5	6.7	17.3	4.7	10.3	6.5
DEC-FY20	6.6	17.9	12.4	4.7	7.7	13.4	37.0	19.0	6.3

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the healthcare system's explanation for the increased wait times for the community-based outpatient clinic in Framingham, MA.

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

Number of Days

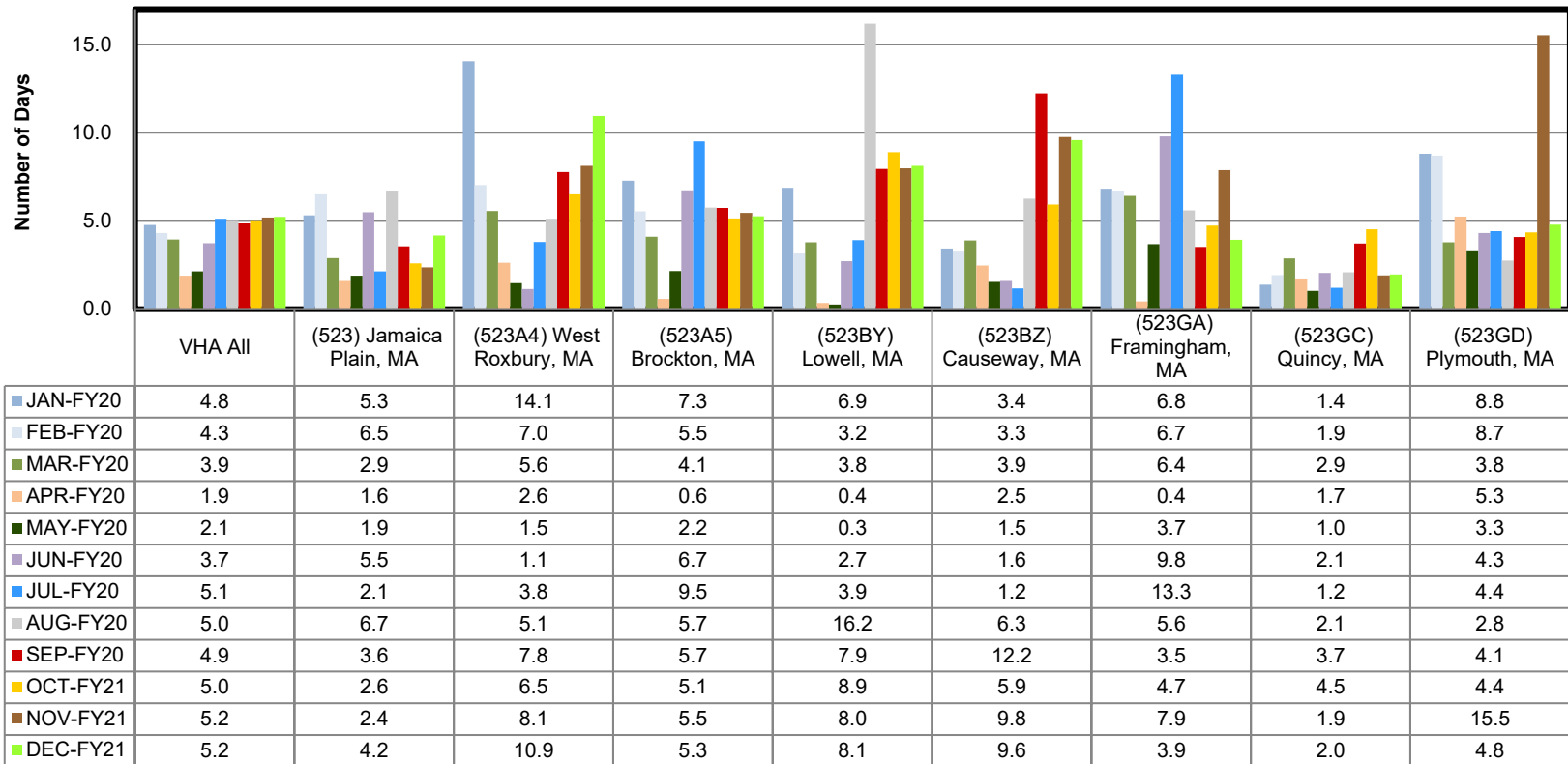|	VHA All	(523) Jamaica Plain, MA	(523A4) West Roxbury, MA	(523A5) Brockton, MA	(523BY) Lowell, MA	(523BZ) Causeway, MA	(523GA) Framingham, MA	(523GC) Quincy, MA	(523GD) Plymouth, MA
JAN-FY20	4.8	5.3	14.1	7.3	6.9	3.4	6.8	1.4	8.8
FEB-FY20	4.3	6.5	7.0	5.5	3.2	3.3	6.7	1.9	8.7
MAR-FY20	3.9	2.9	5.6	4.1	3.8	3.9	6.4	2.9	3.8
APR-FY20	1.9	1.6	2.6	0.6	0.4	2.5	0.4	1.7	5.3
MAY-FY20	2.1	1.9	1.5	2.2	0.3	1.5	3.7	1.0	3.3
JUN-FY20	3.7	5.5	1.1	6.7	2.7	1.6	9.8	2.1	4.3
JUL-FY20	5.1	2.1	3.8	9.5	3.9	1.2	13.3	1.2	4.4
AUG-FY20	5.0	6.7	5.1	5.7	16.2	6.3	5.6	2.1	2.8
SEP-FY20	4.9	3.6	7.8	5.7	7.9	12.2	3.5	3.7	4.1
OCT-FY21	5.0	2.6	6.5	5.1	8.9	5.9	4.7	4.5	4.4
NOV-FY21	5.2	2.4	8.1	5.5	8.0	9.8	7.9	1.9	15.5
DEC-FY21	5.2	4.2	10.9	5.3	8.1	9.6	3.9	2.0	4.8

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.

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	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
Care transition	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like – HED90_1	Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient behavioral health screening, prevention, immunization, and tobacco	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS composite score related to outpatient care for diabetes and ischemic heart disease	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value

Measure	Definition	Desired Direction
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	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 hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	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 Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 31, 2021

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts

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

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

1. I have reviewed and concur with the response for the draft report of the Comprehensive Healthcare Inspection of the VA Boston Healthcare System and Jamaica Plain Division.

2. I have reviewed the Healthcare System Director's action plan and projected completion dates. I concur with the plan and have complete confidence that the plan will be effective. VISN 1 will assist the Healthcare System's leadership in reaching full compliance in a timely manner.

3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Ryan Lilly, MPA

Director, VA New England Healthcare System

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: August 31, 2021

From: Director, VA Boston Healthcare System (523/00)

Subj: Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts

To: Director, VA New England Healthcare System (10N1)

1. In response to the VA Office of Inspector General (OIG) Inspection of the VA Boston Healthcare System, I concur with the recommendations.

2. The VA Boston Healthcare System submits the attached status update providing justification and documentation to recommendation numbers 1 through 8. I concur with the VA Boston Healthcare System action plan and ongoing implementation for recommendations 1 through 8.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information please contact the Associate Director, Quality Management.

(Original signed by:)

Vincent Ng (523/00)

Healthcare System Director

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