DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds

CHIP REPORT | REPORT #21-00263-246 | SEPTEMBER 14, 2021

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Figure 1. *VA Central Western Massachusetts Healthcare System in Leeds.*

Source: https://vaww.va.gov/directory/guide/ (*accessed January 28, 2021*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
DBRS	Disruptive Behavior Reporting System
FY	fiscal year
OIG	Office of Inspector General
PMDB	prevention and management of disruptive behavior
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 Central Western Massachusetts Healthcare System, which includes multiple outpatient clinics located 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 areas:

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)[2]
5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)[3]
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 Central Western Massachusetts Healthcare System during the week of February 1, 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

[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)."

[2] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the VA Central Western Massachusetts Healthcare System in Leeds because system staff did not administer remdesivir during the review period.

[3] The OIG's review of mental health focused on emergency department and urgent care center suicide risk screening and evaluation. This review was not performed at the VA Central Western Massachusetts Healthcare System in Leeds because the system did not have an emergency department and the urgent care center closed in March 2020.

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) 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 five recommendations to the System Director, Chief of Staff, and Associate Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the healthcare system's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. Organizational communications and accountability were managed through a committee reporting structure, with Executive Council of the Governing Body oversight of several working groups. Leaders monitored patient safety and care through the Quality Safety Values Executive Council, 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 seven months. The Associate Director for Patient Care Services, who was permanently assigned in May 2014, was the most tenured leader. The Chief of Staff and Associate Director had served in their positions since April and December 2017, respectively. The Director, who was assigned in June 2020, was the newest member of the leadership team.

The OIG reviewed employee satisfaction survey results and found that scores related to the Chief of Staff, Associate Director for Patient Care Services, and Associate Director were consistently better than those for VHA and the healthcare system. However, the Director had opportunities to reduce employee feelings of moral distress and improve workgroup respect and sharing of concerns.[4] Selected patient experience survey scores generally reflected similar or higher care ratings than the VHA average, except for female patients' ability to secure timely patient-centered medical home and specialty care appointments. Patients appeared generally satisfied with the care provided.

[4] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The 2020 All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[5]

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." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[6]

The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures and Community Living Center SAIL measures.[7] 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.

Care Coordination

The OIG observed general compliance with requirements for an inter-facility transfer policy and VA *Inter-Facility Transfer Form* or facility-defined equivalent note documentation addressing the reason, date, and time of transfer; medical and behavioral stability of the patient; and mode of transportation. However, the OIG identified deficiencies with staff monitoring and evaluating inter-facility transfers, obtaining patients' informed consent, identifying the receiving physician in transfer documentation, supervising non-physicians initiating patient transfers, sending copies of patients' advance directives, and documenting nurse-to-nurse communication between sending and receiving facilities.

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

[6] "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.)

[7] 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.

High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with Disruptive Behavior Committee meeting attendance, Disruptive Behavior Reporting System use, and staff training.

Conclusion

The OIG conducted a detailed inspection across six key areas (two administrative and four clinical) and subsequently issued five recommendations for improvement to the System Director, Chief of Staff, and Associate Director for Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for system leaders to use the recommendations to help guide improvements in operations and clinical care. The recommendations address issues 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 50–51, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Central Western Massachusetts 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): e005055, https://doi.org/10.1136/bmjopen-2014-005055.

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

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

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

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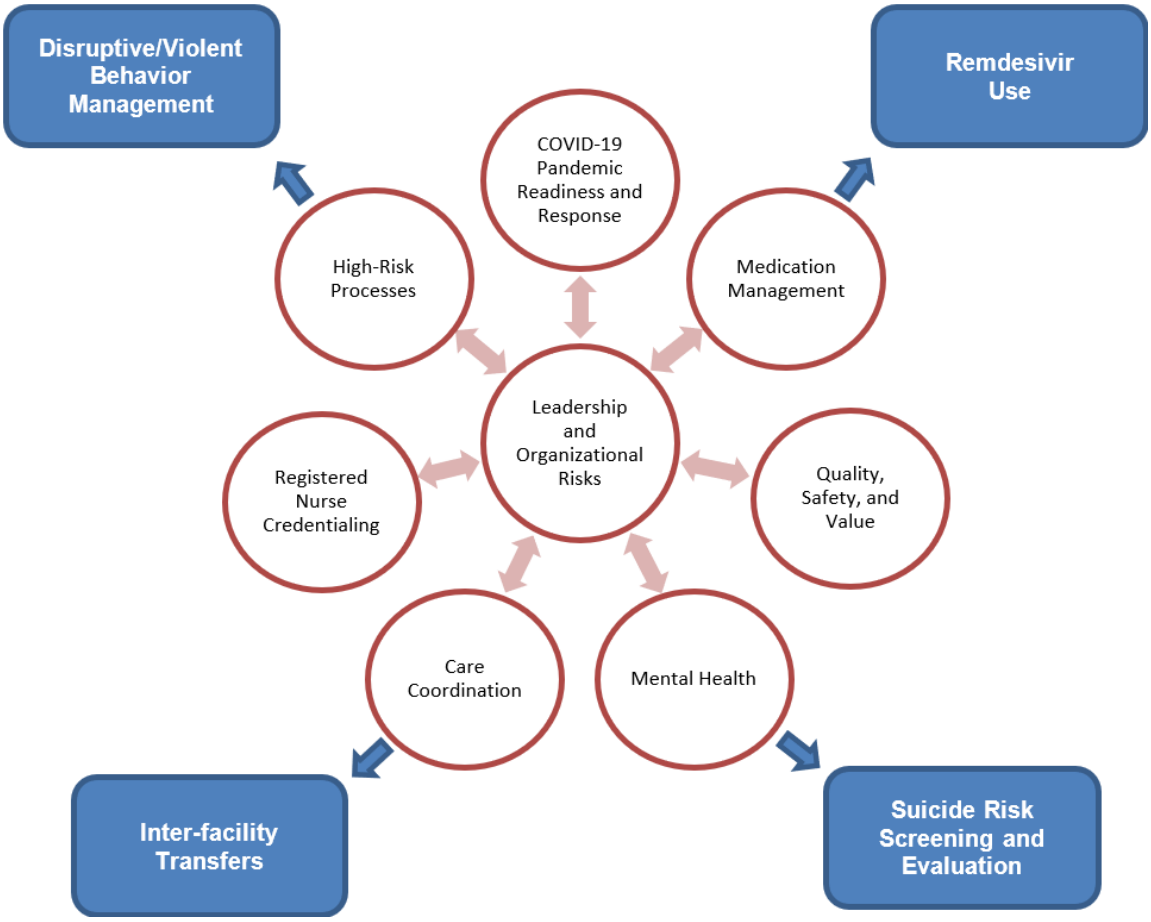


***Figure 2**. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

[6] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the VA Central Western Massachusetts Healthcare System in Leeds because system staff did not administer remdesivir during the review period.

[7] The OIG's review of mental health focused on emergency department and urgent care center suicide risk screening and evaluation. This review was not performed at the VA Central Western Massachusetts Healthcare System in Leeds because the system did not have an emergency department and the urgent care center closed in March 2020.

Methodology

The VA Central Western Massachusetts Healthcare System includes several outpatient clinics located 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.[8] The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from June 8, 2019, through February 5, 2021, the last day of the unannounced multiday evaluation.[9] During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

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.[10] 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.

[8] The OIG did not review VHA's internal survey results and instead focused on OIG inspections and external surveys that affect facility accreditation status.

[9] The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in February 2021.

[10] 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.[11] 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))[12]

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 Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

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

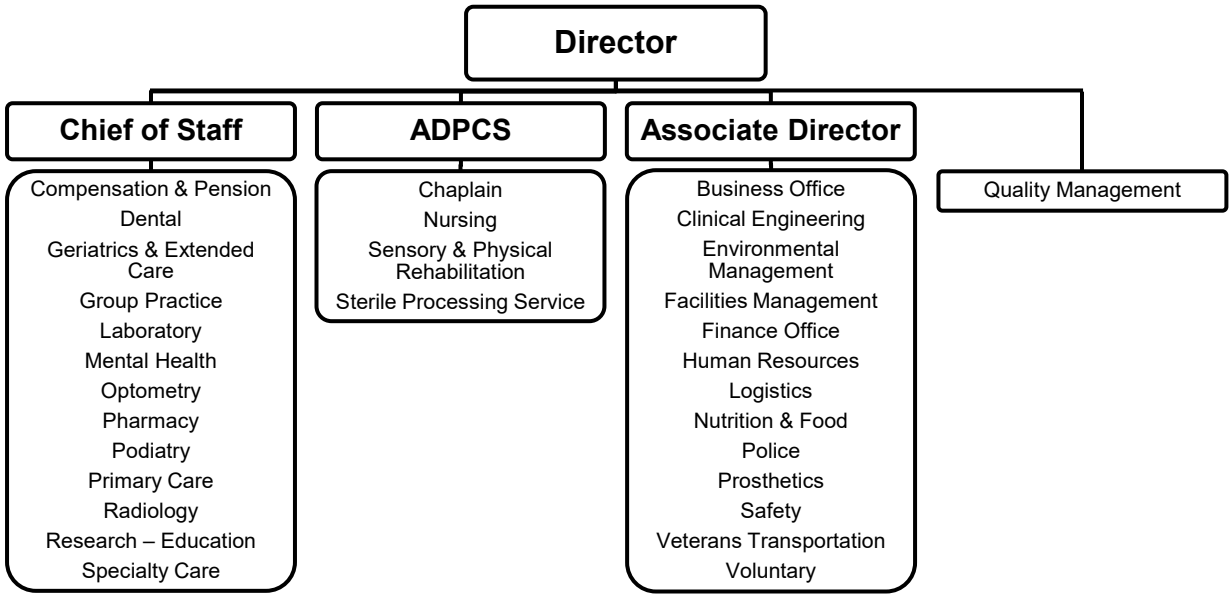


Figure 3. *Healthcare system organizational chart.*
Source: VA Central Western Massachusetts Healthcare System (received February 1, 2021).

At the time of the OIG inspection, the executive team had worked together for seven months. However, the Chief of Staff, ADPCS, and Associate Director had served in their roles for over three years (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	June 7, 2020
Chief of Staff	April 2, 2017
Associate Director for Patient Care Services	May 4, 2014
Associate Director	December 10, 2017

Source: VA Central Western Massachusetts Healthcare System Senior Strategic Business Partner VISN 1 (received February 1, 2021).

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

The executive leaders were generally 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 and CLC SAIL metrics. 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 Executive Council of the Governing Body was the system's designated executive committee to oversee various working groups such as the Healthcare Operations, Healthcare Delivery, and Organizational Health Councils. System leaders monitored patient safety and care through the Quality Safety Values Executive Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Council of the Governing Body (see figure 4).

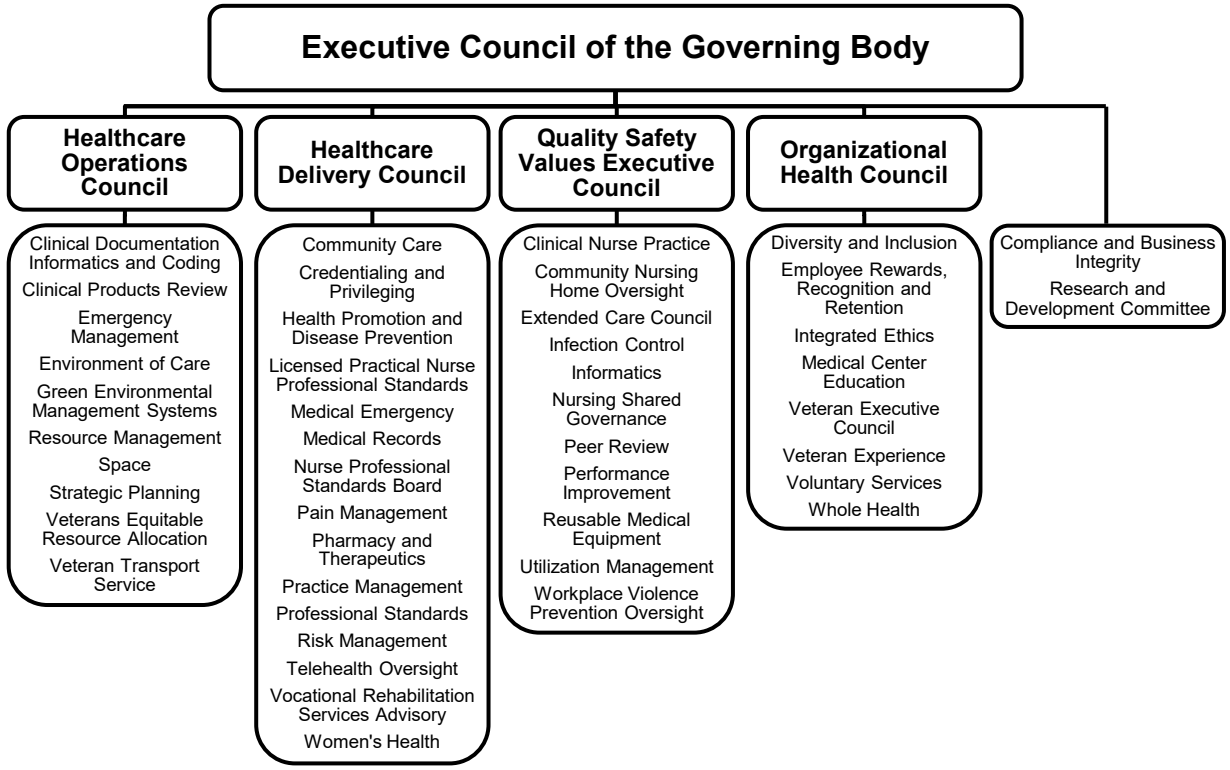


Figure 4. *Healthcare system committee reporting structure.*
Source: VA Central Western Massachusetts Healthcare System (received February 1 and April 9, 2021).

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $289,996,002 increased 19 percent compared to the previous year's budget of $243,601,825.[13] When asked about the effect of this change on the healthcare system's operations, the Director discussed how difficult it was to manage a budget while maintaining operations during the pandemic.

[13] VHA Support Service Center.

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 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 facility-reported clinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[17] The Director confirmed that occupations listed in table 2 remained some of the top priorities for clinical staffing. The Chief of Staff reported additional staffing shortages, including inpatient psychiatry, primary care providers, and radiologists. The Director identified challenges recruiting nursing staff and specialty care providers due to the rural location, and with the Associate Director, reported providing a 10 percent specialty pay rate for staff working in Environmental Management, Police, and Food and Nutrition Services. Additionally, the Chief of Staff cited challenges recruiting providers due to salary competition, and the ADPCS reported improvement with nursing vacancies after holding a job fair prior to the pandemic and maintaining flexible hiring practices during the pandemic.

Table 2. Top Facility-Reported Clinical Staffing Shortages

Top Clinical Staffing Shortages*
1. Nurse
2. RN Staff Nurse–Inpatient
3. Practical Nurse
4. Nursing Assistant

Source: VA OIG.

**The facility did not report nonclinical staffing shortages.*

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

[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.*

Employee Satisfaction

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

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[19] Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. 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 similar to or higher than the VHA averages.[20] The Director's scores were similar to or higher, and the Chief of Staff, ADPCS, and Associate Director's scores were consistently higher than those for VHA and the healthcare system.[21]

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	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	76.8	78.3	86.8	85.4	90.3

[18] "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.)

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

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

[21] The 2020 All Employee Survey results are not fully representative of employee satisfaction with the Director, who assumed the role in June 2020.

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.4	3.4	4.3	3.8	4.2
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.6	3.7	4.4	3.9	4.7
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	3.9	4.4	4.1	4.6

Source: VA All Employee Survey (accessed January 4, 2021).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[22] The healthcare system averages for the selected survey questions were similar to the VHA averages. Scores for the Chief of Staff, ADPCS, and Associate Director were consistently better than those for VHA and the healthcare system. However, opportunities appeared to exist for the Director to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

The Director reported conducting a Town Hall on the topics of a just culture and psychological safety and discussed the importance of having a transparent and blameless organization because most errors are related to systems, not people. According to the Director, the healthcare system is ranked within the top 10 percent for psychological safety within the state. The Director explained

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

the focus on breaking down silos and promoting teamwork so staff are comfortable reporting concerns.

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	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.3	4.7	4.1	4.7
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	3.6	4.2	3.9	4.1
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	1.3	1.7	1.2	1.0	1.1

Source: VA All Employee Survey (accessed January 4, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment." 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.[23]

The Director described efforts to support a harassment-free environment, including those through the Diversity and Inclusion Committee. The committee serves as a low threat environment where questions and answers can be freely discussed and includes a panel where staff may join the discussion and ask questions. Two discussion panels had been completed and were reportedly well-received by staff. The Director spoke about resuming these discussions, along with diversity and inclusion training.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The healthcare system and executive leadership team averages for the selected survey questions were similar to or better than the VHA averages, except for the Director's scores regarding workgroup respect and ability to bring up problems and tough issues, which were lower than the VHA and healthcare system averages. Leaders appeared to maintain an environment where staff felt respected and safe and discrimination was not tolerated.

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.0	4.0	3.7	4.4	4.4	4.7
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.1	4.2	4.2	4.6	4.3	4.7

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
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	3.6	4.6	4.2	4.7

Source: VA All Employee Survey (accessed January 4, 2021).

Patient Experience

To assess patient experiences with the healthcare system, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through September 30, 2020. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and 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.[24] The OIG reviewed responses to two relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the healthcare system.[25] For this healthcare system, the overall patient satisfaction survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	86.3

[24] This healthcare system does not have acute medical-surgical inpatient beds.

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

Questions	Scoring	VHA Average	Healthcare System Average
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	88.6

Source: VHA Office of 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.[26] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for the Patient-Centered Medical Home and Specialty Care surveys (see tables 7–8). The results for male respondents were generally similar to or more favorable than the corresponding VHA averages. Although female respondents rated their providers favorably, their responses indicated opportunities to increase primary care and specialty care appointment availability. System leaders appeared to be actively engaged with patients; the Director identified plans to provide female veterans with one point of contact for all services in the healthcare system. The Associate Director also described a dedicated women's health clinic and an inpatient unit for female veterans requiring treatment for post-traumatic stress disorder. The Director reported that due to the age of the medical center, many generations had been served and patients were thought of as neighbors.

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

Table 7. 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	63.7	54.1
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).	59.5	53.0	63.6	47.6
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	75.2	81.2

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

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

The healthcare system averages are based on 429–1,400 male and 24–62 female respondents, depending on the question.

Table 8. 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	59.5	9.0

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).	57.4	54.3	67.0	23.3
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	82.3	91.2

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 241–784 male and 15–36 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[27] Table 9 summarizes the relevant healthcare system inspections performed by the OIG and The Joint Commission (TJC).[28] In June 2018, the healthcare system received a preliminary denial for the hospital accreditation from TJC for patterns, trends, and/or repeat findings. The healthcare system had a successful re-review in August 2018 and received accreditation. At the time of the OIG virtual review, the healthcare system had closed all but five recommendations for improvement issued since the previous CHIP site visit conducted in June 2019. The system also had seven open recommendations from an OIG hotline inspection conducted in November 2019.

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

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

Interviews with the Director and Chief of Staff confirmed that appropriate steps were being taken towards closure of the remaining open recommendations.

The OIG team also noted the healthcare system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities, the College of American Pathologists, and the Long Term Care Institute's inspection of the system's CLCs.[29]

Table 9. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts*, Report No. 19-00038-63, January 13, 2020)	June 2019	30	5*
OIG (*Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds,* Report No. 19-09669-236, August 20, 2020)	November 2019	7	7
TJC Hospital Accreditation	June 2018	49	0
TJC Behavioral Health Care Accreditation		9	0
TJC Home Care Accreditation		5	0

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC Hospital Accreditation: Unannounced Onsite Preliminary Denial of Accreditation Review	August 2018	0	–

Source: OIG and TJC (inspection/survey results received from the Accreditation Coordinator on February 2, 2021).

**As of August 2021, one recommendation remained open.*
As of August 2021, there were no open recommendations.

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 10 lists the reported patient safety events from June 3, 2019 (the prior OIG CHIP site visit), to February 1, 2021.[30]

Table 10. Summary of Selected Organizational Risk Factors (June 3, 2019, to February 1, 2021)

Factor	Number of Occurrences
Sentinel Events	0
Institutional Disclosures	3
Large-Scale Disclosures	0

Source: VA Central Western Massachusetts Healthcare System's Patient Safety and Risk Managers (received February 1, 2021).

The Director stated that all adverse events are reported by the Patient Safety Manager and evaluated through the root causes analysis process as applicable.[31] The Director also reported that the VISN Quality Management Officer conducted a review to assess the healthcare system's quality management processes. The OIG's review of the system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.

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

[30] 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 Central Western Massachusetts Healthcare System is a low complexity (3) 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."

[31] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[32]

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 the VA Central Western Massachusetts Healthcare System's performance in the first through fourth 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, mental health (MH) experience (exp) of care, SC care coordination, and MH population (popu) coverage). Metrics in the fourth quintile are those that need improvement and are denoted in orange (for example, emergency department (ED) throughput).[33]

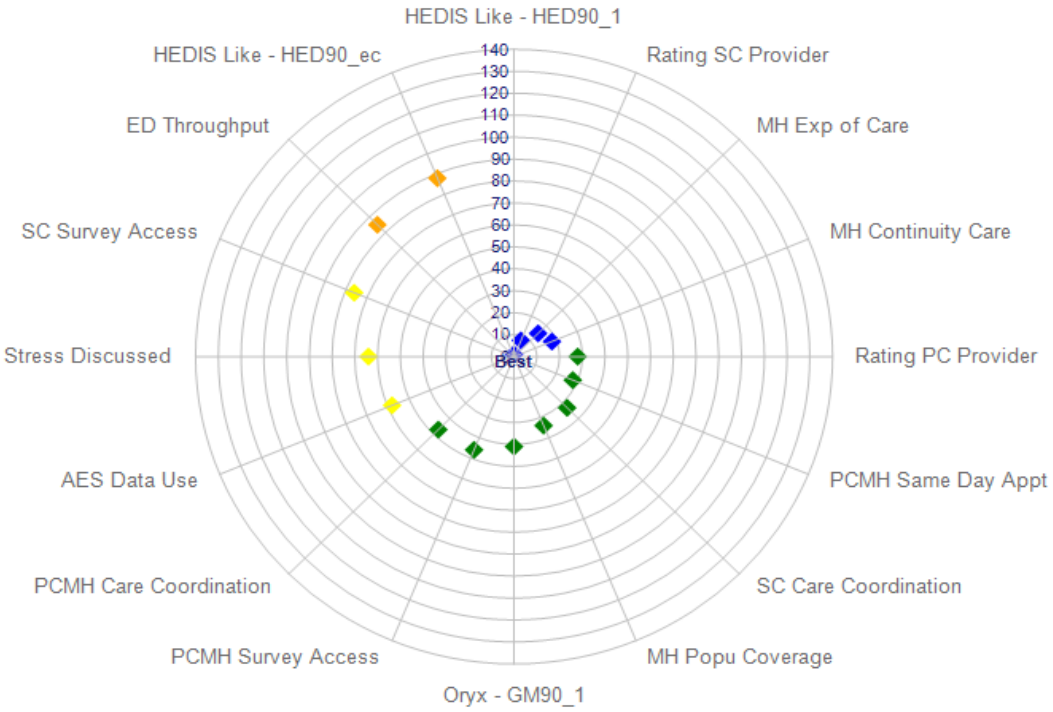


Figure 5. *System quality of care and efficiency metric rankings, FY 2020 quarter 3 (as of June 30, 2020).*

Source: VHA Support Service Center.

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

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

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

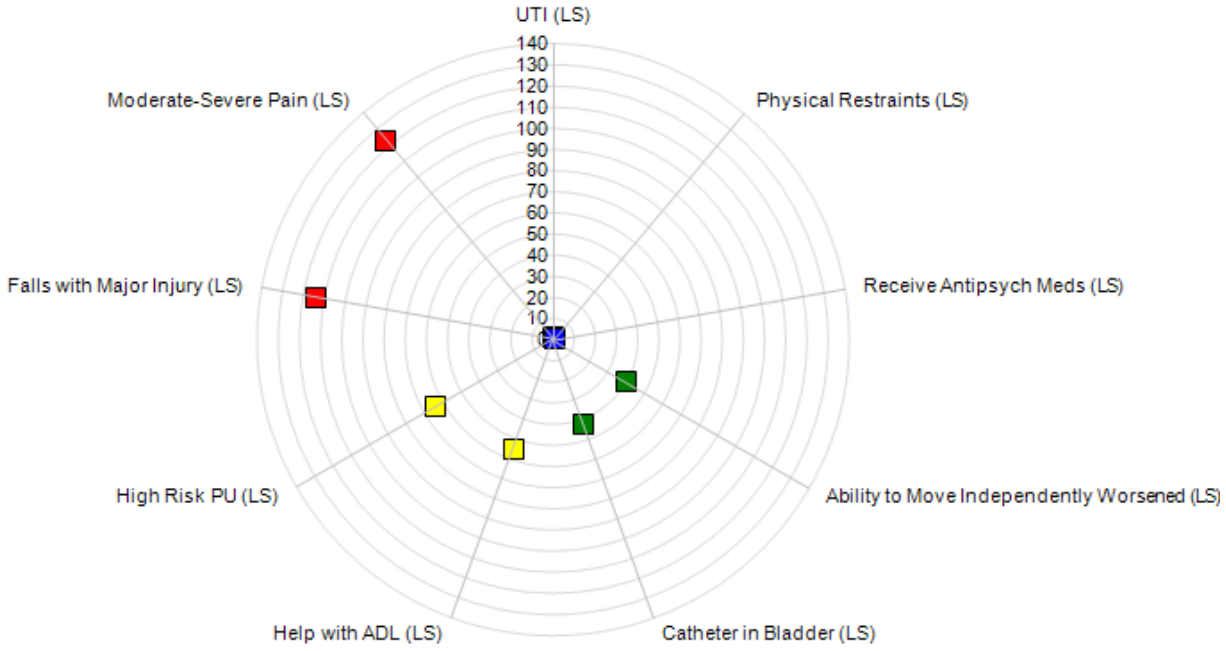
Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA." 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."[34]

Figures 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 Northampton (VA Central Western Massachusetts Healthcare System) CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of physical restraints–long-stay (LS) and ability to move independently worsened (LS)). Metrics in the fifth quintile need improvement and are denoted in red (falls with major injury (LS) and moderate-severe pain (LS)).[35]

[34] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, July 23, 2020. "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."

[35] 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. *Northampton CLC quality measure rankings, 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

At the time of the virtual review, the healthcare system's leaders had worked together for seven months. The ADPCS, permanently assigned in May 2014, was the most tenured leader. The Director, assigned in June 2020, was the newest member of the leadership team. The executive leaders were able to discuss interim strategies to address clinical occupational shortages.

Selected employee survey results related to the Chief of Staff, ADPCS, and Associate Director were consistently better than those for VHA and the healthcare system. However, opportunities appeared to exist for the Director to reduce employee feelings of moral distress at work and improve workgroup respect and sharing of concerns. Selected patient experience survey scores generally reflected similar or higher care ratings than the VHA average, except for female patients' ability to secure timely patient-centered medical home and specialty care appointments. Patients appeared generally satisfied with the care provided.

The OIG's review of the hospital's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.

The executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL measures and should continue to take actions to sustain and improve performance on quality measure ratings.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[36] 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.[37]

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."[38] "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."[39]

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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[36] "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.

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

[38] 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."

[39] 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.[40] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[41] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as 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."[42]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the 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."[43] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[44] The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator
- Tracking of facility-level performance improvement capability and projects
- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group
- Staff education on performance improvement principles and techniques

[40] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[41] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[42] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence.*
[43] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.
[44] VHA Directive 1026.01.

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[45] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[46] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[47] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[48]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[49]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed VHA facilities' compliance with selected surgical program requirements. The OIG did not conduct this aspect of the review because the healthcare system did not have a surgical program.

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, and other relevant information.[50]

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

[46] VHA Directive 1190.

[47] VHA Directive 1190.

[48] VHA Directive 1190.

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

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

Quality, Safety, and Value Findings and Recommendations

Generally, the healthcare system met the above requirements. The OIG made no recommendations.

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."[51] 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."[52]

VA requires all RNs to hold at least one active, unencumbered license.[53] 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.[54] 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.[55] 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.[56]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key employees and managers and reviewing relevant documents for 16 RNs hired between January 1, 2020, and January 3, 2021. The OIG determined whether

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

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

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

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

[53] 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."

[54] 38 U.S.C. § 7402.

[55] VHA Directive 2012-030.

[56] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[57]

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."[58] 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.[59]

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 53 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.[60]

Care Coordination Findings and Recommendations

The OIG observed general compliance with requirements for an inter-facility transfer policy and VA *Inter-Facility Transfer Form* or facility-defined equivalent note documentation addressing the reason, date, and time of transfer; medical and behavioral stability of the patient; and mode of

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

[58] VHA Directive 1094.

[59] 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.

[60] Fifty of the electronic health records reviewed were from the urgent care center and the remaining three were from the system's mental health areas. The healthcare system closed the urgent care center in March 2020.

transportation. However, the OIG identified concerns with staff obtaining patients' informed consent, identifying the receiving physician in transfer documentation, supervising non-physicians initiating patient transfers, sending copies of patients' advance directives, and documenting nurse-to-nurse communication between sending and receiving facilities. Since the healthcare system ceased urgent care center operations on March 1, 2020, the OIG made no recommendations.

Additionally, the OIG identified a deficiency with healthcare system staff monitoring and evaluating inter-facility transfers.

VHA requires that the Chief of Staff and ADPCS ensure "all transfers are monitored and evaluated as part of VHA's Quality Management Program."[61] The OIG did not find evidence that staff monitored and evaluated patient transfers from February 1, 2020, through January 31, 2021. Failure to monitor and evaluate patient transfer data could hinder the identification of system-level deficiencies, jeopardize patients' health, and inhibit the healthcare system's ongoing performance improvement activities. The Chief of Staff stated that historically, facility staff did not report patient transfer data and acknowledged lack of awareness of this requirement. The acting Chief of Quality Management reported focusing on exceptions and not trends over time.

Recommendation 1

1. The System Director evaluates and determines reasons for noncompliance and makes certain that all transfers are monitored and evaluated as part of Veterans Health Administration's Quality Management Program.

[61] VHA Directive 1094.

Healthcare system concurred.

Target date for completion: May 31, 2022

Healthcare system response: The System Director reviewed and found a lack of awareness of the requirement as a reason for noncompliance. The quality management nurse will review 10% of interfacility transfers monthly for compliance to each element required per VHA Directive 1094 Interfacility Transfer Policy and report results to the Quality Safety and Values Executive Council. Review of transfer data has been added as a standing item to the agenda of the Quality Safety and Values Executive Council. Data will include a review performed by a quality management nurse of each interfacility transfer for compliance with each required element per Directive VHA 1094. The facility Quality Manager will review the minutes for compliance with monitoring and evaluating transfer data. The facility will demonstrate compliance through Quality Safety and Value Executive Council chaired by the System Director, minutes that demonstrate review of transfer data 90% of the time for six consecutive months.

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."[62] 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."[63] 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[64]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[65]
- Use of the Disruptive Behavior Reporting System (DBRS) to document the decision to implement an Order of Behavioral Restriction[66]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[67]

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

[63] VHA Directive 2012-026.

[64] 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."

[65] 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."

[66] 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."

[67] 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.[68] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[69] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG observed compliance with the establishment of a policy for reporting and tracking disruptive behavior, the Employee Threat Assessment Team and Disruptive Behavior Committee, and completion of the annual Workplace Behavioral Risk Assessment. However, the OIG identified deficiencies with Disruptive Behavior Committee meeting attendance, DBRS use, and staff training.

VHA requires that the Chief of Staff and Nurse Executive (ADPCS) are responsible for establishing a disruptive behavior committee or board that includes a senior clinician as the chairperson; clerical and administrative support staff; the patient advocate; and representatives from the Prevention and Management of Disruptive Behavior (PMDB) Program, VA police, patient safety and/or risk management, and the Union Safety Committee.[70]

The OIG reviewed attendance for the 11 Disruptive Behavior Committee meetings held from February 2020 through January 2021 and found the PMDB Program and patient safety or risk management representatives did not attend 3 of 11 (27 percent) meetings and administrative support staff did not attend 2 of 11 (18 percent) meetings.[71] This could have resulted in a lack of knowledge and expertise when assessing patients' disruptive behavior. The PMDB representative and Patient Safety Manager reported conflicting work assignments, lacking assigned alternate staff, and being on leave as reasons for not attending the meetings. The OIG

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

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

[70] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

[71] Union Safety Committee representative also did not attend but was not included in the finding based on *Executive Order Ensuring Transparency, Accountability, and Efficiency in Taxpayer Funded Union Time Use*, Issued May 25, 2018.

observed that clerical and administrative support staff attendance was only captured by the employee's signature (documenting the recording of minutes); therefore, attendance could not be verified for meeting minutes not provided. The Disruptive Behavior Committee Chair explained that meeting minutes for February and May 2020 could not be located and was unable to provide a reason why.

Recommendation 2

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

Healthcare system concurred.

Target date for completion: April 30, 2022

Healthcare system response: The Chief of Staff and the Associate Director for Patient Care Service evaluated and found no additional reasons for noncompliance. Attendance of required members will be monitored by the Quality Safety and Values Executive Council that will review Disruptive Behavior Committee minutes for attendance that meets compliance. Quality Safety and Values Executive Council will then report the status of attendance monitoring to the Executive Committee of the Governance Board. Successful resolution of the recommendation will be demonstrated with 6 consecutive months of Disruptive Behavior Committee meeting minutes that demonstrate 90% attendance by required members.

VHA requires the "facility Chief of Staff's designee, the DBC [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."[72] The OIG found that system staff did not use the DBRS to document the decision to implement an Order of Behavioral Restriction or patient notification. Documenting the decision to implement an Order of Behavioral Restriction and patient notification using the DBRS provides a standardized reporting and tracking mechanism, which promotes safety in medical facilities. The Disruptive Behavior Committee Chair reported being unaware of the requirement. The chair also reported that disruptive patient events were documented using the patient record flag system and believed this process met the requirement.

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

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures staff document decisions to implement an Order of Behavioral Restriction and patient notifications in the Disruptive Behavior Reporting System.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff reviewed and found no additional reasons for noncompliance. Tracking of Order of Behavioral Restriction documentation in Disruptive Behavior Reporting System has been added as a standing agenda item for Disruptive Behavior Committee. The Disruptive Behavior Committee Chair will report monthly compliance data to the Quality Safety and Values Executive Council as the percentage of Orders of Behavioral Restriction each month documented in Disruptive Behavior Reporting System. The facility will demonstrate 90% compliance for six consecutive months.

VHA requires that staff are assigned prevention and management of disruptive behavior part 1 training at hire and "additional levels of PMDB training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment."[73] The OIG reviewed the training records for 30 staff and found 14 had not completed the required training based on their assigned risk level. This could result in lack of awareness, preparedness, and precautions when responding to disruptive behavior. The PMDB Coordinator reported that prior to COVID-19, the system provided parts 1 and 2 training to all staff during new employee orientation, and part 3 was assigned based on the risk level associated with the work area. The Coordinator further stated that pandemic-related social distancing protocols led to the cancellation of parts 1 and 2 trainings during new employee orientation, as well as part 3 training. Per the Coordinator, part 1 training was then assigned through the Talent Management System. However, four staff failed to complete the training despite frequent automated notifications to both the staff and their supervisor.

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

Recommendation 4

4. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[74]

Healthcare system concurred.

Target date for completion: July 31, 2022

Healthcare system response: The System Director reviewed and found no additional reasons for noncompliance. Completion of required prevention and management of disruptive behavior training is monitored by the facility Prevention and Management of Disruptive Behavior Coordinator. Due to the pandemic, the initial module of the Prevention and Management of Disruptive Behavior training is now being completed in the Talent Management System within 90 days of hire, as face to face training for additional modules remains on hold. With current resurgence of COVID cases dates for restarting face to face training have not been identified. Once community COVID positive prevalence drops to levels safe for face to face training, the face to face training will resume with a prioritization of those who have waited longest receiving training first. The 4 staff who were found deficient in completion of Phase 1 of the required training at the time of the inspection have completed the training modules as assigned. The Prevention and Management of Disruptive Behavior Coordinator will monitor compliance of the assigned training completions and will report levels of compliance to Disruptive Behavior Committee and to the Quality Safety and Values Executive Council until 90% compliance of timely completion of required trainings is met for 6 consecutive months.

VHA requires the chair and members of the Employee Threat Assessment Team to complete specific workplace violence prevention program training.[75] The OIG found that two staff assigned to the Employee Threat Assessment Team had not completed the required trainings. This could result in the failure to address potential employee-generated workplace aggression or violence and identify risk mitigation strategies. The Employee Threat Assessment Team Co-Chair reported being unaware of the training requirement.

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

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

Recommendation 5

5. The System Director evaluates and determines reasons for noncompliance and ensures the chair and members of the Employee Threat Assessment Team complete the required training.

Healthcare system concurred.

Target date for completion: February 28, 2022

Healthcare system response: The System Director reviewed and found no additional reasons for noncompliance. The Chair of Employee Threat Assessment Team reviewed the training requirements and status of completion with members of the Employee Threat Assessment Team. The members verbalized understanding, and training will be tracked by the Chair of the Employee Threat Assessment Team for compliance. The Chair of the Employee Threat Assessment Team will report to the Quality Safety and Values Executive Council monthly, current levels of required training completion for Employee Threat Assessment Team members. Sustainment of this recommendation will be demonstrated with 6 consecutive months of 90% Employee Threat Assessment Team members completing training as required. The team members delinquent at the time of inspection have all completed the required training.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of six clinical and administrative areas and provided five recommendations on 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 guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines five 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 Director, Chief of Staff, and ADPCS. The intent is for thee leaders to use these recommendations to guide improvements in operations and clinical care. The recommendations address 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)	• None	• 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	• None
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
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	• None	• All transfers are monitored and evaluated as part of VHA's Quality Management Program.

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
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	• Staff document decisions to implement an Order of Behavioral Restriction and patient notifications in the Disruptive Behavior Reporting System.	• Required members attend Disruptive Behavior Committee meetings. • Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas. • The chair and members of the Employee Threat Assessment Team complete the required training.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) healthcare system reporting to VISN 1.[1]

Table B.1. Profile for VA Central Western Massachusetts Healthcare System (631) (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	$226,396,218	$243,601,825	$289,996,002
Number of:			
• Unique patients	27,997	28,064	26,675
• Outpatient visits	386,091	399,785	324,623
• Unique employees§	795	799	795
Type and number of operating beds:	32	32	32
• Community living center			
• Mental health	81	81	81
• Residential rehabilitation	16	16	16
Average daily census:	21	29	26
• Community living center			
• Mental health	50	54	45
• Residential rehabilitation	13	14	10

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

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

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

[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

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
Springfield, MA	631BY	9,906	6,718	Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Neurology Podiatry	EKG Laboratory & Pathology	Nutrition Pharmacy Prosthetics Weight management
Pittsfield, MA	631GC	2,512	1,692	Dermatology Endocrinology Neurology	EKG	Nutrition Prosthetics Weight management

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

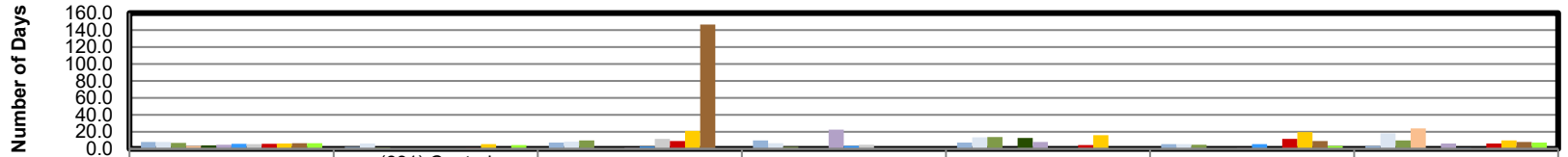
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Greenfield, MA	631GD	2,223	2,160	Dermatology Endocrinology General surgery Neurology	EKG	Nutrition Pharmacy Prosthetics Weight management
Worcester, MA	631GE	8,841	405	Endocrinology Eye Infectious disease	EKG Laboratory & Pathology Radiology	Nutrition Pharmacy Prosthetics Weight management
Fitchburg, MA	631GF	3,193	1,791	Endocrinology	EKG	Nutrition Pharmacy Prosthetics Weight management
Worcester, MA	631QB	–	4,281	Anesthesia Cardiology Dermatology Nephrology Neurology Rheumatology	EKG	Nutrition Prosthetics Weight management

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (631QA) Worcester, MA as no data were reported.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days



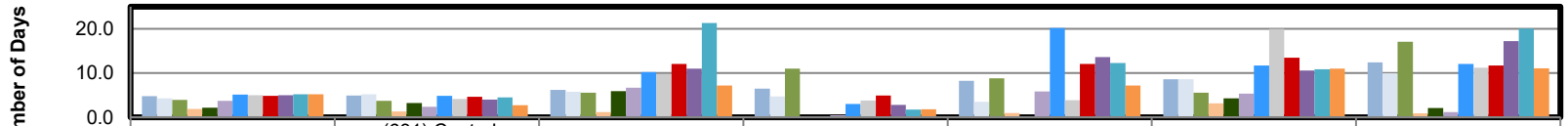
	VHA All	(631) Central Western Massachusetts, MA (Edward P. Boland)	(631BY) Springfield, MA	(631GC) Pittsfield, MA	(631GD) Greenfield, MA	(631GE) Worcester, MA	(631GF) Fitchburg, MA
JAN-FY19	8.3	2.4	7.4	9.9	7.5	5.7	3.5
FEB-FY19	8.1	6.2	8.5	6.9	13.5	5.6	18.4
MAR-FY19	6.9	1.5	10.0	2.4	14.0	4.8	10.0
APR-FY19	3.6	0.0	0.0	n/a	n/a	0.5	24.0
MAY-FY19	4.0	0.0	0.0	n/a	13.0	0.7	0.0
JUN-FY19	4.9	0.3	1.4	22.8	8.0	1.0	6.5
JUL-FY19	5.9	0.5	2.5	3.4	0.0	5.7	0.8
AUG-FY19	5.6	0.2	11.8	5.0	n/a	0.5	0.0
SEP-FY19	6.1	1.0	9.3	0.0	4.5	11.9	6.4
OCT-FY20	6.3	5.7	21.2	0.3	16.0	19.8	10.0
NOV-FY20	6.7	0.4	146.6	0.0	n/a	9.1	8.3
DEC-FY20	6.6	4.6	0.3	0.0	n/a	3.6	7.4

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 (631BY) Springfield, MA Community Based Outpatient Clinic. The Director cited a scheduling error, patient cancellations, and COVID-19 as contributing factors for the increased wait times. The OIG omitted (631QA) Worcester, MA and (631QB) Lake Avenue, MA as no data were reported.

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



	VHA All	(631) Central Western Massachusetts, MA (Edward P. Boland)	(631BY) Springfield, MA	(631GC) Pittsfield, MA	(631GD) Greenfield, MA	(631GE) Worcester, MA	(631GF) Fitchburg, MA
JAN-FY20	4.8	5.0	6.2	6.5	8.2	8.6	12.4
FEB-FY20	4.3	5.2	5.8	4.7	3.5	8.6	9.9
MAR-FY20	3.9	3.7	5.5	11.0	8.8	5.6	17.1
APR-FY20	1.9	1.3	1.2	0.0	1.0	3.2	0.9
MAY-FY20	2.1	3.2	5.9	0.0	0.0	4.3	2.1
JUN-FY20	3.7	2.4	6.7	0.5	5.8	5.3	1.2
JUL-FY20	5.1	4.8	10.2	3.0	20.2	11.7	12.1
AUG-FY20	5.0	4.2	9.7	3.8	3.8	20.0	11.2
SEP-FY20	4.9	4.7	12.1	4.9	12.0	13.5	11.7
OCT-FY21	5.0	4.0	11.0	2.8	13.6	10.5	17.2
NOV-FY21	5.2	4.5	21.3	1.8	12.3	10.8	20.0
DEC-FY21	5.2	2.7	7.2	1.8	7.2	11.0	11.1

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 omitted (631QA) Worcester, MA and (631QB) Lake Avenue, MA as no data were reported.

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
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
ED Throughput	Composite measure for timeliness of care in the emergency department	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
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
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower 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
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.
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.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
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 16, 2021

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

Subj: Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds

To: Director, Office of Healthcare Inspections (54CH03)

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 Central Western Massachusetts Healthcare System in Leeds.

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.

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

(Original signed by:)

Ryan S. Lilly, MPA

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: August 3, 2021

From: Director, VA Central Western Massachusetts Healthcare System (631/00)

Subj: Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds

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

1. I have reviewed the findings within the Comprehensive Healthcare Inspection for the VA Central Western Massachusetts Healthcare System in Leeds.

2. The plan for corrective actions has been reviewed and approved by the medical center executive leadership team.

(Original signed by:)

Duane B. Gill

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