



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the VA NY
Harbor Healthcare System in
New York



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Figure 1. VA NY Harbor Healthcare System in New York.

Source: <https://www.va.gov/new-york-harbor-health-care/> (accessed June 23, 2021).

Abbreviations

ADPS	Associate Director, Patient Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
ED	emergency department
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
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 NY Harbor Healthcare System, which includes the Brooklyn, Manhattan, and St. Albans VA Medical Centers and associated outpatient clinics in New York. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

The OIG team looks at leadership and organizational risks, and at the time of the inspection, focused on the following additional seven areas:

1. COVID-19 pandemic readiness and response¹
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)
5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
6. Care coordination (spotlighting inter-facility transfers)
7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual inspection of the VA NY Harbor Healthcare System during the week of June 28, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help this healthcare system and other Veterans Health Administration (VHA)

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

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

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the healthcare system's leadership team consisted of the System Director; Deputy Director; Executive Chief of Staff; Associate Director, Patient Services; Associate Director, Facilities; and Associate Director, Finance. The Director assumed the role in July 2010; the Associate Director, Patient Services in July 2004; and Executive Chief of Staff in January 2017. These three leaders had worked together for almost four and a half years. The deputy director position was created in January 2021 but had not been filled. An individual was detailed to the associate director, facilities position in February 2021 after it had been vacant for over two and a half years. The associate director, finance position was vacated in January 2021 and remained vacant at the time of the virtual inspection. The Director reported that it was difficult to find suitable candidates given the cost of living in the New York area and that the system was trying to develop their own leaders. The Director and Assistant Human Resources Officer stated that the acting Assistant Director temporarily covered some of the responsibilities of the vacant associate director, finance position.

The healthcare system's fiscal year 2020 annual medical care budget decreased 2.2 percent compared to the previous year's budget. The executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Employee satisfaction survey scores for system leaders were generally similar to or better than the VHA averages. Selected patient experience survey data implied satisfaction with the outpatient care provided. However, the results for male and female inpatient respondents were significantly less favorable than the corresponding VHA averages. The results for male and female patient-centered medical home (primary care) respondents show more favorable ratings of providers compared to corresponding VHA averages. While both male and female respondents scored their specialty care experiences favorably compared to VHA averages, male respondents rated providers slightly lower.

The OIG reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and identified deficiencies related to sentinel events and institutional disclosures.²

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.”³ The executive leaders were generally knowledgeable within their scope of responsibilities and tenure about VHA data and factors contributing to poor performance on specific SAIL measures. Leaders also had an understanding of Community Living Center SAIL measures.⁴ In individual interviews, the executive leadership team members were generally able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

The OIG reported 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.⁵

Quality, Safety, and Value

The healthcare system complied with most of the requirements for a committee responsible for quality, safety, and value oversight functions, the Systems Redesign and Improvement Program, and the Surgical Work Group. However, the OIG identified a weakness with protected peer review processes.⁶

² VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.” VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”

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

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

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

⁶ VHA Directive 1190. A peer review is a “critical review of care, performed by a peer,” to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements.

Medication Management

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

Mental Health

The healthcare system complied with requirements related to suicide prevention screening within emergency departments and urgent care centers. However, staff responsible for suicide safety plan development had not consistently completed the required training.

Care Coordination

Generally, the healthcare system met expectations for monitoring and evaluation of inter-facility transfers and nurse-to-nurse communication between facilities. However, the OIG identified deficiencies with completion of all required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent note and transmission of an active medication list and advance directive to the receiving facility. The OIG issued repeat findings related to these deficiencies, which had been previously identified during the June 2017 CHIP site visit.⁷

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, Orders of Behavioral Restriction, and staff training.

⁷ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer. VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA New York Harbor Healthcare System, New York, New York*, Report No. 17-01762-88, February 7, 2018.

Conclusion

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

VA Comments

The Veterans Integrated Service Network Director and interim System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 67–68, 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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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 NY Harbor 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 inspection, paused physical inspection steps (especially those involved in the environment of care-focused review topic), and initiated a COVID-19 pandemic readiness and response evaluation.

As such, to examine risks to patients and the organization, the OIG focused on core processes in the following eight areas of administrative and clinical operations (see figure 2):⁴

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response⁵
3. Quality, safety, and value
4. Registered nurse credentialing

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

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

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

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

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

5. Medication management (targeting remdesivir use)
6. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
7. Care coordination (spotlighting inter-facility transfers)
8. High-risk processes (examining the management of disruptive and violent behavior)

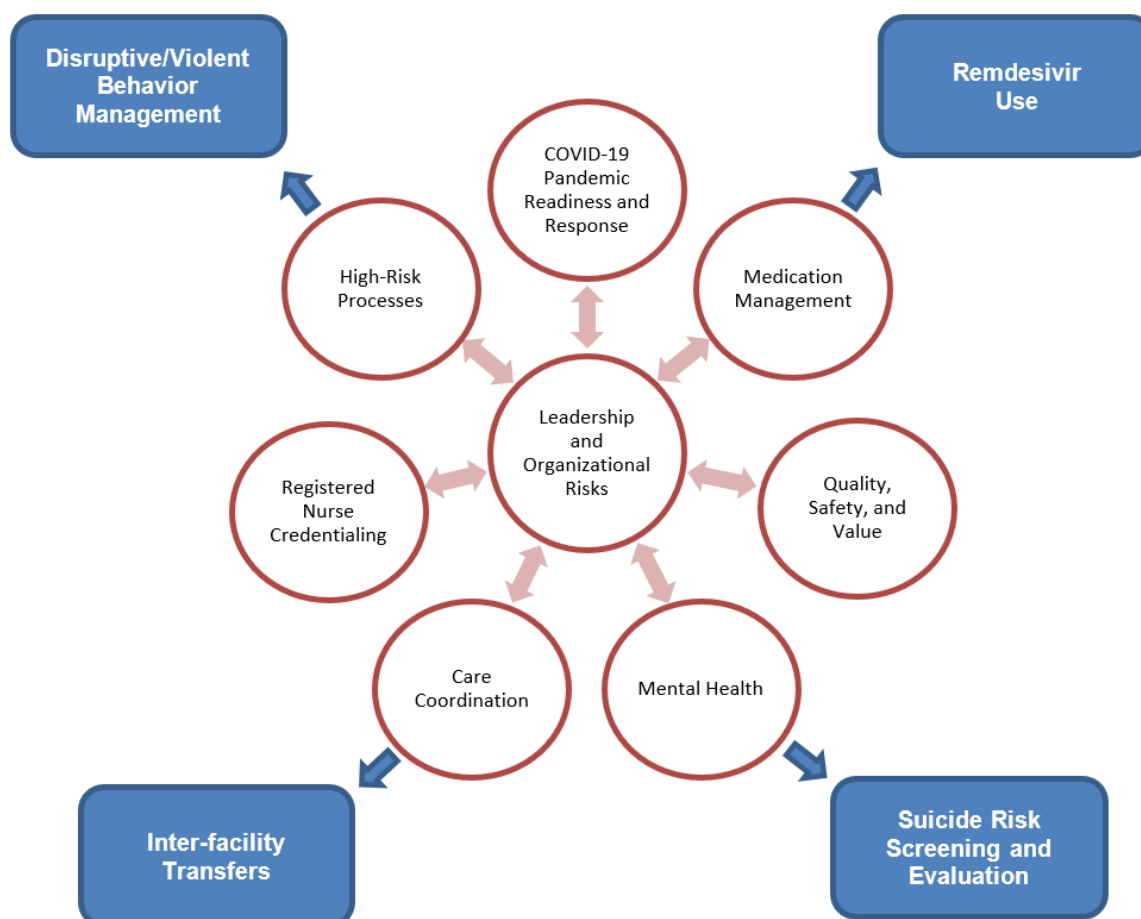


Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.

Source: VA OIG.

Methodology

The VA NY Harbor Healthcare System includes the Brooklyn, Manhattan, and St. Albans VA Medical Centers, and associated outpatient clinics in New York. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from June 24, 2017, through July 2, 2021, the last day of the unannounced multiday evaluation.⁷ During the virtual site visit, the OIG did not receive any concerns beyond the scope of the inspection.

The OIG reported 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.⁸

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁹ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁶ The OIG did not review VHA's internal survey results and instead focused on OIG inspections and external surveys that affect facility accreditation status.

⁷ The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in July 2021.

⁸ VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

⁹ Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect a healthcare system's ability to provide care in the clinical focus areas.¹⁰ To assess this 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))¹¹

Executive Leadership Position Stability and Engagement

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

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

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

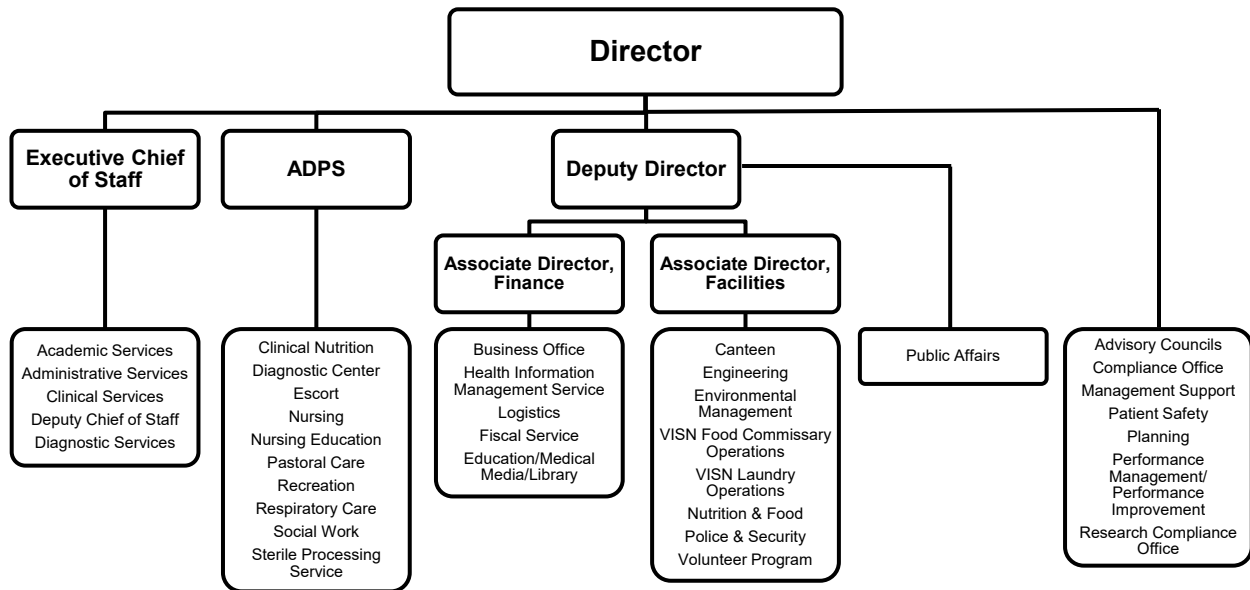


Figure 3. Healthcare system organizational chart.

Source: VA NY Harbor Healthcare System (received June 28, 2021).

At the time of the OIG inspection, the System Director, Executive Chief of Staff, and ADPS had worked together for almost four and a half years (see table 1). The Director assumed the role in July 2010, the ADPS in July 2004, and the Executive Chief of Staff in January 2017. The deputy director position was created in January 2021 but had not been filled. An individual was detailed to the associate director, facilities position in February 2021 after it had been vacant for over two and a half years. The associate director, finance position was vacated in January 2021 and remained vacant at the time of the virtual inspection. The Director reported that it was difficult to find suitable candidates given the cost of living in the New York area and that the system was developing their own leaders. The Director and Assistant Human Resources Officer stated that the acting Assistant Director temporarily covered some of the responsibilities of the vacant associate director, finance position.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
System Director	July 18, 2010
Deputy Director	Vacant
Executive Chief of Staff	January 8, 2017
Associate Director, Patient Services	July 25, 2004
Associate Director, Facilities	February 1, 2021 (acting)
Associate Director, Finance	Vacant

Source: VA NY Harbor Healthcare System Assistant Human Resources Officer and Director (received June 28–30, 2021).

The Director served as the chairperson of the Executive Council, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Council oversaw various working groups such as the Clinical Executive Board, and Environment of Care and Management of Information Committees. These leaders monitored patient safety and care through the Executive Council, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).¹²

¹² The Executive Council Policy stated that the Executive Council reported to the Governing Body. The Performance Measurement and Planning/Performance Improvement Manager verified that the Governing Body was comprised solely of the System Director.

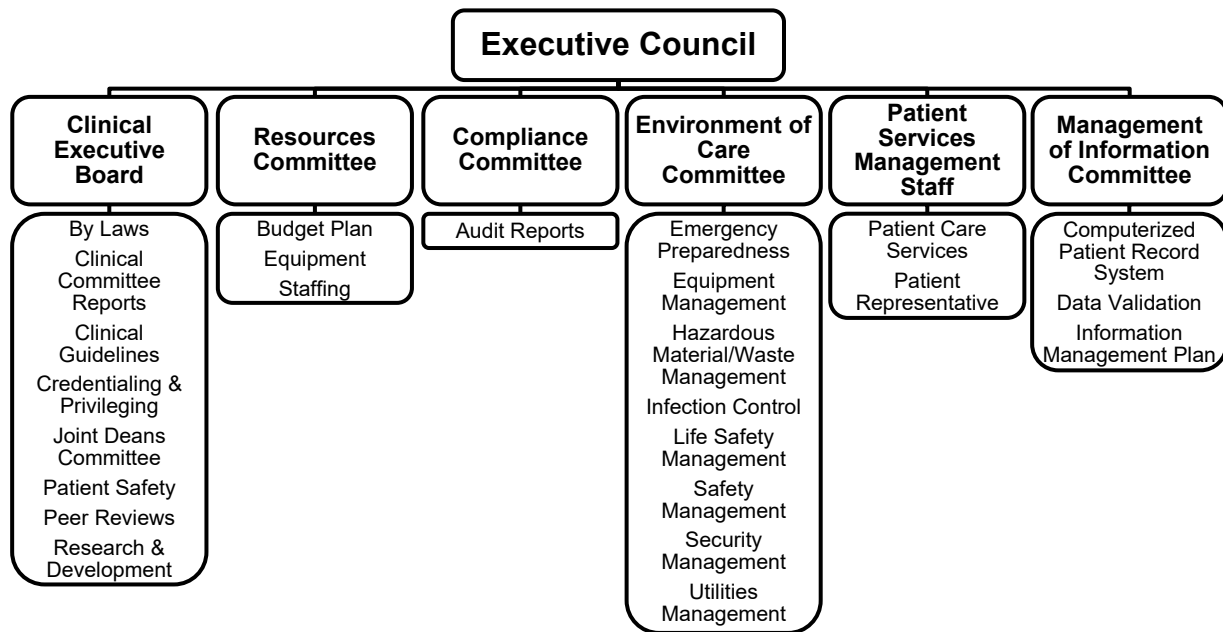


Figure 4. Healthcare system committee reporting structure.

Source: VA NY Harbor Healthcare System (received July 1, 2021).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the Director; Executive Chief of Staff; ADPS; and Associate Director, Facilities regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the executive leaders were generally knowledgeable within their scope of responsibilities and tenure about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of \$747,223,777 decreased 2.2 percent compared to the previous year's budget of \$763,946,446.¹³ When asked about the effect of this change on the healthcare system's operations, the Director indicated that the budget was adequate because additional COVID-19 funds that were not reflected in the budget were allocated and used to hire permanent outpatient staff.

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 and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.¹⁷ The executive leaders confirmed that occupations listed in table 2 generally remained the top clinical and nonclinical shortages at the time of the OIG inspection, except for engineers who were hired recently after a salary increase for that job classification. Additionally, leaders shared that low VHA pay, compared to New York City private sector pay, contributed to the staffing shortages. The Director reported working with NYU [New York University] Langone Health to help mitigate the specialty surgeon shortage with dual appointment staff.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Vascular Surgery*	1. Police
2. Cardiovascular/Thoracic Surgeon*	2. Electrician
3. Nurse Anesthetist	3. Plumbing
4. Orthopedic Surgery*	4. Boiler Plant Operator
5. Pain Management/Anesthesia*	5. General Engineering

Source: VA OIG.

*Denotes specific assignment codes (types) within the Medical Officer occupational series.

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.”¹⁸ Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health.¹⁹ 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, 2020.²⁰ Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. The OIG found the healthcare system averages for the selected survey leadership questions were lower than VHA averages.²¹ However, scores related to the Director; ADPS; and Associate Director, Finance were consistently higher than those for VHA and the healthcare system.²²

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 “AES Survey History.”

²⁰ Ratings are based on responses by employees who report to or are aligned under the Director, Executive Chief of Staff, ADPS, and Associate Director, Finance.

²¹ The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

²² The 2020 All Employee Survey results are not reflective of employee satisfaction with the current acting Associate Director, Facilities, who assumed the role after the survey was administered.

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	Executive Chief of Staff Average	ADPS Average	Assoc. Director, Finance Average
All Employee Survey: <i>Servant Leader Index Composite.*</i>	0–100 where higher scores are more favorable	73.8	68.9	93.0	73.1	80.3	74.4
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.3	4.3	3.5	3.6	3.7
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.4	4.6	3.8	3.9	3.7
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.6	4.5	3.7	3.8	3.8

Source: VA All Employee Survey (accessed May 27 and June 7, 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.²³ The healthcare system averages for the selected survey questions were less

²³ Ratings are based on responses by employees who report to or are aligned under the Director, Executive Chief of Staff, ADPS, and Associate Director, Finance.

favorable than VHA averages. Scores related to the Director and ADPS were consistently better than those for VHA and the healthcare system.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Executive Chief of Staff Average	ADPS Average	Assoc. Director, Finance Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.7	4.5	3.8	4.2	3.7
All Employee Survey: <i>Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.7	4.4	3.7	4.1	3.9
All Employee Survey: <i>In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?</i>	0 (Never)– 6 (Every Day)	1.4	1.6	0.8	1.6	1.3	1.5

Source: VA All Employee Survey (accessed May 27 and June 7, 2021).

VHA leaders have articulated that the agency “is committed to a harassment-free healthcare environment.”²⁴ To this end, leaders initiated the “Stand Up to Stop Harassment Now!” campaign to help create a culture of safety where staff and patients feel secure and respected.²⁵

The Director reported implementing strategies from VA’s “Stand Up to Stop Harassment Now!” campaign.²⁶ To demonstrate commitment to a culture of safety, the Director discussed signing the declaration on day one of the campaign and displaying posters of it throughout the system.

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 generally similar to or better than the VHA averages, except for the ADPS, who has an opportunity to improve how people treat each other in workgroups. Leaders appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.

²⁴ “Stand Up to Stop Harassment Now!” Department of Veterans Affairs, accessed December 8, 2020, <https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/>. (This is an internal website not publicly accessible.) Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

²⁵ “Stand Up to Stop Harassment Now!”

²⁶ Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*.

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

Questions/ Survey Items	Scoring	VHA Average	Health- care System Average	Director Average	Executive Chief of Staff Average	ADPS Average	Assoc. Director, Finance Average
All Employee Survey: <i>People treat each other with respect in my workgroup.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	3.8	4.3	3.9	3.7	3.8
All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	4.1	3.9	4.8	4.1	4.3	4.1
All Employee Survey: <i>Members in my workgroup are able to bring up problems and tough issues.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.7	4.5	3.8	3.8	3.8

Source: VA All Employee Survey (accessed May 27 and June 7, 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 (primary care), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides survey results for VHA and the healthcare system.²⁷ For this system, the overall inpatient satisfaction survey result reflected a lower care rating than the VHA average while outpatient satisfaction survey results reflected higher care ratings. Patients appeared satisfied with the outpatient care provided but were less likely to recommend the hospital to friends and family.

²⁷ Ratings are based on responses by patients who received care at this healthcare system.

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

Questions	Scoring	VHA Average	System Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	69.5	62.9
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	82.5	83.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	84.8	88.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (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 2048.²⁸ For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients’ experiences by gender, including those for Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys (see tables 7–9). The results for male and female inpatient respondents were significantly less favorable than the corresponding VHA averages. The Chief of Staff stated that providers had started to sit down and give their undivided attention to the patient during visits. The ADPS reported that nurses were decreasing noise levels as much as possible on the inpatient units.

The results for patient-centered medical home respondents indicated that male and female patients rated primary care providers favorably, and male patients perceived that they were able to get an appointment for care needed right away. Although both male and female respondents generally scored their specialty care experiences more favorably than VHA respondents

²⁸ “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.

nationally, male respondents rated providers slightly lower. When asked about actions taken to improve women veterans' experience in the inpatient and primary care settings, system leaders reported being actively engaged with female patients (for example, by conducting veteran town hall meetings on women's issues and virtual baby showers).

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>Would you recommend this hospital to your friends and family?</i>	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	64.3	37.0
<i>During this hospital stay, how often did doctors treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	82.8	71.3
<i>During this hospital stay, how often did nurses treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	80.8	53.4

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

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

†The healthcare system averages are based on 646–655 male and 30–33 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	57.8	26.1
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	57.7	52.1
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	82.5	71.2

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 352–852 male and 30–48 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	58.4	79.7
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	62.0	67.0
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	73.8	86.7

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

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

†The healthcare system averages are based on 459–1,064 male and 22–55 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.²⁹ Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint

²⁹ “Profile Definitions and Methodology: Joint Commission Accreditation,” *American Hospital Directory*, accessed December 12, 2020, https://www.ahd.com/definitions/prof_accred.html. “The Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff, or reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.”

Commission (TJC).³⁰ At the time of the OIG inspection, the system had closed all recommendations for improvement issued since the previous CHIP site visit conducted in June 2017. However, the OIG identified repeat findings related to completion of the VA *Inter-Facility Transfer Form* and transmission of required information to the receiving facility, which is discussed in greater detail in the Care Coordination section of this report. The OIG team also noted a focused OIG evaluation on patient feeding and institutional disclosure processes with a report that was published on June 22, 2021, a week before the virtual inspection.³¹ The Planning Performance Measurement/Performance Improvement Manager reported working with system managers to address the seven recommendations.

Lastly, the OIG team noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists as well as results from the Long Term Care Institute's inspection of the system's CLC.³²

³⁰ 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."

³¹ VA OIG, *Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens*, Report No. 20-02968-170, June 22, 2021.

³² 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.ltcior.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."

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Comprehensive Healthcare Inspection Program Review of the VA New York Harbor Healthcare System, New York, New York, No. 17-01762-88, February 7, 2018</i>)	June 2017	14	0
OIG (<i>Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens, Report No. 20-02968-170, June 22, 2021</i>)	July 2020	7	7*
TJC Hospital Accreditation	February 2018	56	0
TJC Behavioral Health Care Accreditation		2	0
TJC Home Care Accreditation		19	0
TJC Behavioral Health Care and Human Services	January 2021	7	0

Source: OIG and TJC (TJC survey results received from the Accreditation Specialist on June 28, 2021).

*As of May 2022, two recommendations remained open.

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

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

Table 11 lists the reported patient safety events from June 24, 2017 (the prior OIG CHIP site visit), through June 28, 2021.³³

Table 11. Summary of Selected Organizational Risk Factors (June 24, 2017, through June 28, 2021)

Factor	Number of Occurrences
Sentinel Events	9
Institutional Disclosures	3
Large-Scale Disclosures	0

Source: VA NY Harbor Healthcare System Planning Performance Measurement/Performance Improvement Manager and Patient Safety Manager (received June 28 and July 1, 2021).

The Director stated that the executive leadership team learned about adverse patient events during the daily morning huddle. The Director also reported referring to the local policy and consulting with the Performance Planning Measurement/Performance Improvement Manager and Executive Chief of Staff to determine when an institutional disclosure was warranted.

Although the Director was able to discuss the adverse event reporting process, the OIG noted concerns related to leaders identifying sentinel events and conducting institutional disclosures for those events. These concerns are discussed in greater detail in the findings and recommendations section.

³³ 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 NY Harbor Healthcare System is a high complexity (1a) affiliated system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.” Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.” 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.”

Veterans' Health Administration Performance Data for the Healthcare System

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.”³⁴ 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.³⁵

Figure 5 illustrates the New York (Manhattan) medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, rating [of] patient-centered medical home (PCMH) provider, PCMH care coordination, and mental health (MH) population coverage). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, hospital rating (HCAHPS), behavioral health (BH90), and care transition (HCAHPS)).³⁶

³⁴ “Strategic Analytics for Improvement and Learning (SAIL) Value Model,” VHA Support Service Center, accessed March 6, 2020, <https://vssc.med.va.gov>. (This is an internal website not publicly accessible.)

³⁵ “Strategic Analytics for Improvement and Learning (SAIL) Value Model.”

³⁶ For information on the acronyms in the SAIL metrics, please see appendix E.

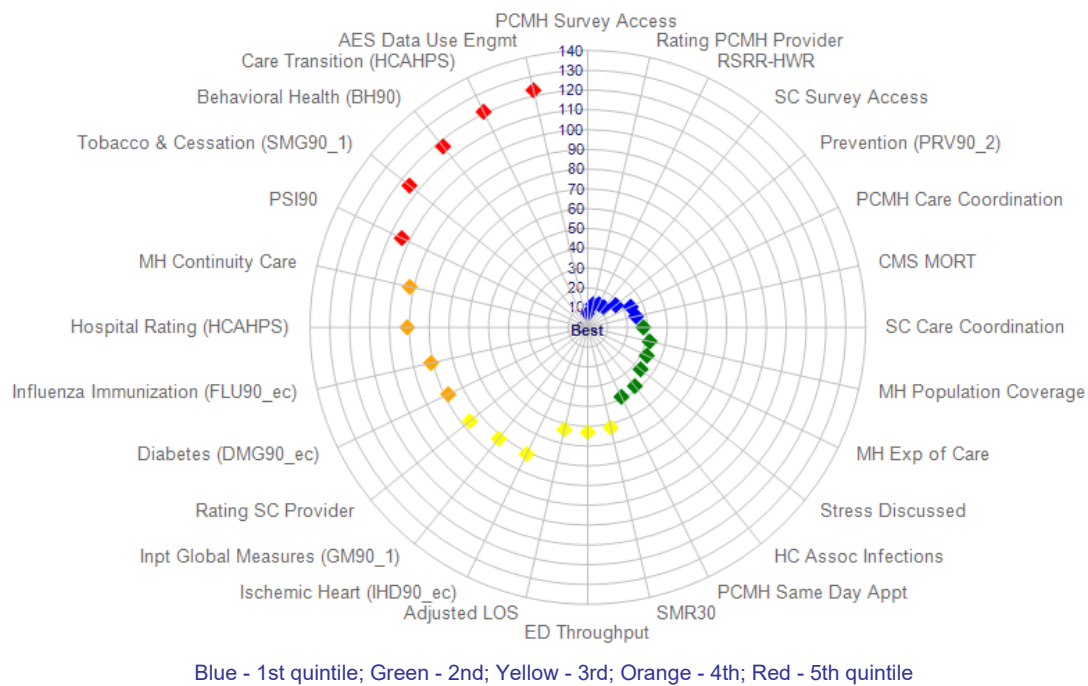


Figure 5. New York (Manhattan) quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 2020).

Source: VHA Support Service Center.

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

Figure 6 illustrates the Brooklyn medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 6 shows performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, rating [of] PCMH provider, stress discussed, and MH population coverage). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, care transition (HCAHPS), BH90, and hospital rating (HCAHPS)).³⁷

³⁷ For information on the acronyms in the SAIL metrics, please see appendix E.

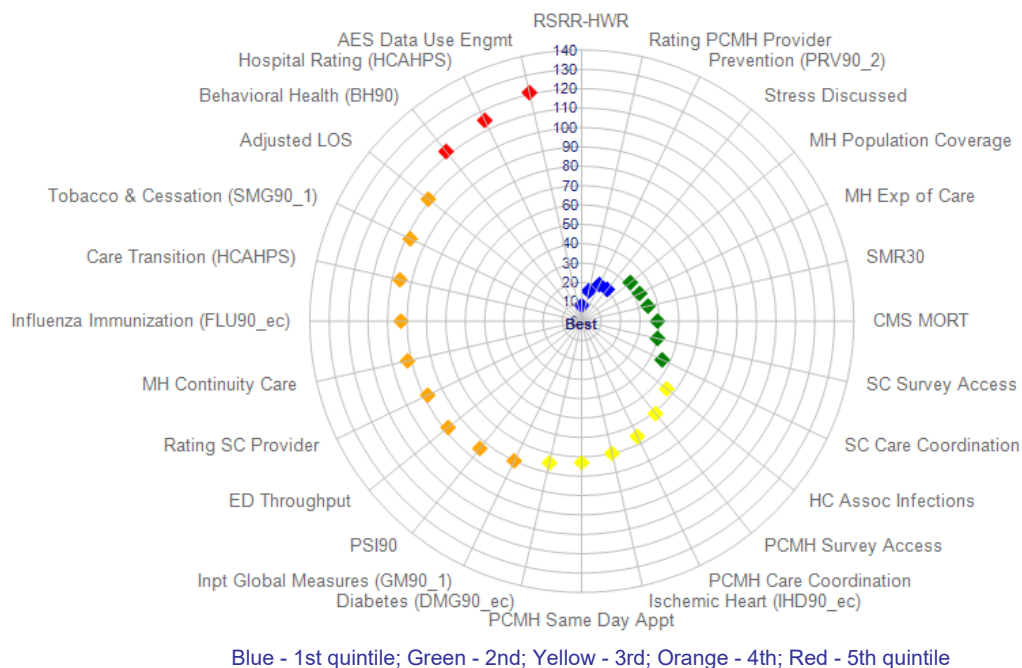


Figure 6. Brooklyn medical center's quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 2020).

Source: VHA Support Service Center.

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

Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to “summarize and compare performance of CLCs in the VA.”³⁸ 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.”³⁹

Figure 7 illustrates the healthcare system’s CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. Figure 7 displays the CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, new or

³⁸ Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks*, July 16, 2021.

³⁹ Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks*. “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its Nursing Home Compare public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

worse pressure ulcer (PU)—short-stay (SS) and urinary tract infection (UTI)—long-stay (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, catheter in bladder (LS) and improvement in function (SS)).⁴⁰

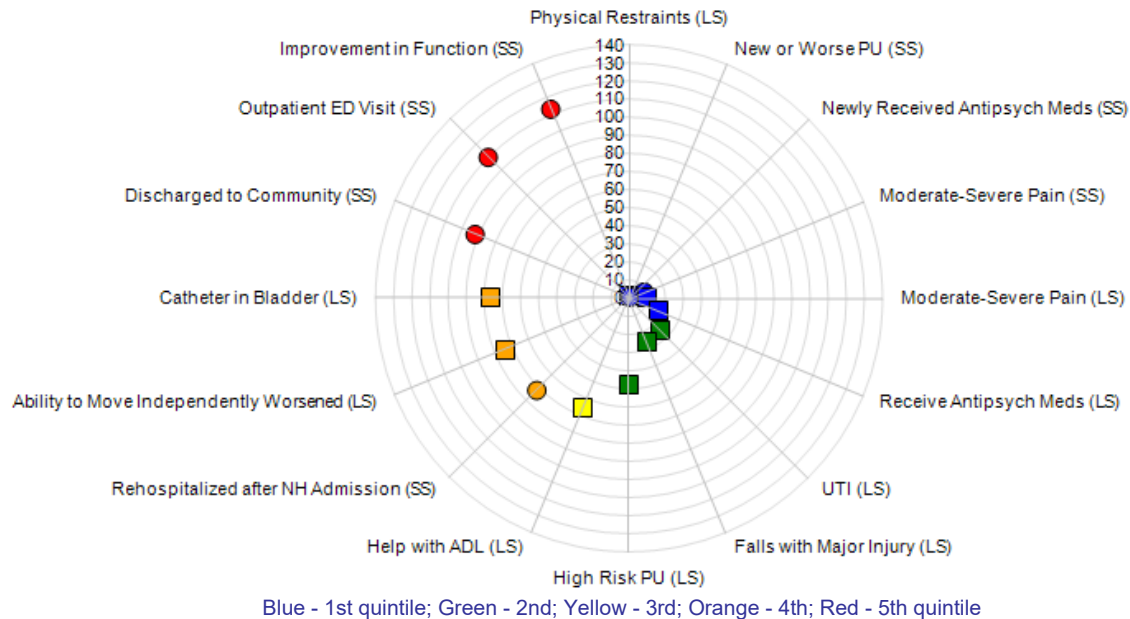


Figure 7. CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).

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.

The executive leaders were generally knowledgeable within their scope of responsibilities and tenure about VHA data and/or factors contributing to poor performance on specific SAIL and CLC SAIL measures. In individual interviews, the executive leadership team members were generally knowledgeable about actions taken during the previous 12 months to maintain or improve organizational performance.

Leadership and Organizational Risks Findings and Recommendations

The system's executive leadership team had vacancies in three of the six key positions since the previous June 2017 OIG CHIP visit, and two of those positions were vacant at the time of OIG's virtual inspection. The executive leaders stated that clinical and nonclinical occupational shortages were due to the high cost of living in the area around the healthcare system and the inability to compete with salaries offered by other healthcare organizations.

⁴⁰ For data definitions of acronyms in the SAIL CLC measures, please see appendix F.

At the time of the inspection, the Director served as the chairperson of the Executive Council, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The healthcare system's FY 2020 annual medical care budget decreased by 2.2 percent compared to the previous year.

Selected employee satisfaction survey responses generally demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated. Patient experience survey data implied overall satisfaction with the outpatient care provided. However, the results for male and female inpatient respondents were less favorable than the corresponding VHA averages.

The executive leaders were generally knowledgeable within their scope of responsibilities and tenure about selected VHA data used by the SAIL and CLC SAIL models. However, the OIG's inspection of inter-facility transfers noted repeat findings from the previous CHIP visit related to completion of the VA *Inter-Facility Transfer Form* and transmission of required information to the receiving facility. The OIG team also noted deficiencies with leaders identifying sentinel events and conducting institutional disclosures.

TJC defines sentinel events as those safety events that reach the patient and result in death, or severe temporary or permanent harm.⁴¹ Furthermore, TJC expects accredited facilities to identify, investigate, and disclose sentinel events to the patient or family.⁴² In support of TJC, VHA established the Patient Safety Program to develop a system that can prevent patient harm. To accomplish this, all facility staff are responsible for reporting any unsafe condition, even if an adverse event has not occurred. In addition, leaders are accountable for identifying sentinel events, conducting a review to determine the root cause, implementing actions to prevent future occurrences, and maintaining an accurate record of all events.⁴³ Furthermore, VHA recognizes that the disclosure of harmful events is "consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence" and requires leaders to inform or disclose a sentinel event to a patient or patient's personal representative when one occurs.⁴⁴ VHA also requires leaders to communicate the disclosure to the patient's representative if the patient is deceased or unable to participate.⁴⁵

The OIG requested information on sentinel events and institutional disclosures completed from June 24, 2017, through June 28, 2021. The Patient Safety Manager and Risk Manager provided documentation for nine sentinel events and three institutional disclosures. The OIG found that

⁴¹ "Sentinel Events Policy and Procedures," The Joint Commission, accessed March 2, 2021, <https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-policy-and-procedures/>.

⁴² "Sentinel Events Policy and Procedures," The Joint Commission.

⁴³ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

⁴⁴ VHA Directive 1004.08.

⁴⁵ VHA Directive 1004.08.

leaders did not conduct institution disclosures for eight of the applicable sentinel events.⁴⁶ Additionally, the OIG found that of the three institutional disclosures conducted, all were sentinel events, but leaders had only identified, reviewed, and taken actions on one as a sentinel event.⁴⁷

The OIG also reviewed Peer Review Committee meeting minutes from March through May 2021 and found that leaders did not properly identify two additional adverse events as sentinel events or conduct institutional disclosures for those occurrences.⁴⁸ Failure to identify sentinel events may lead to missed opportunities for leaders to recognize patient safety trends and report patient harm. Further, failure to perform an institutional disclosure can erode VA's core values and reduce patients' trust in the organization. The Planning Performance Measurement/Performance Improvement Manager and Patient Safety Manager stated that the lack of institutional disclosure of falls with major injury was an oversight.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures that leaders identify adverse events as sentinel events when criteria are met.

⁴⁶ The sentinel events that did not have institutional disclosures included patient death, retained foreign objects, fractures, and a fall.

⁴⁷ The institutional disclosures included a return to the operating room, retained foreign object, and improper disinfection of equipment.

⁴⁸ These two additional adverse events were related to patient falls.

Healthcare system concurred.

Target date for completion: November 30, 2022

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. The Patient Safety Manager, who reports to the System Director, created and implemented the Sentinel Event tracking log on March 1, 2022. The log will capture all relevant adverse event information that meets the Joint Commission sentinel event definitions. The Patient Safety Manager will review all potential events weekly from the morning huddle reports, submitted Joint Patient Safety Reports, issue briefs, and other items received from the Risk Manager, the Planning/Performance Measurement/Performance Improvement Manager (PI), and Quality Management (QM) supervisors, who report to the PI Manager. The Patient Safety Manager will determine if the events meet the sentinel event definition. All sentinel events will be sent by email to the Executive Chief of Staff for concurrence. The Sentinel Event tracking log will be reviewed weekly at the QM huddle with the Risk Manager and PI Manager. The QM huddle aligns under the PI Manager. The Patient Safety Manager will report sentinel events on a quarterly basis to the Clinical Executive Board (CEB). The Executive Chief of Staff is the CEB Chair. The CEB reports monthly to the Executive Council that is chaired by the System Director. Compliance will be achieved when 90 percent of sentinel events have been accurately identified within a six-month period.

Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and ensures that leaders conduct institutional disclosures for all sentinel events.

Healthcare system concurred.

Target date for completion: November 30, 2022

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. The Patient Safety Manager developed and implemented a tracking log on March 1, 2022, that will also track compliance with the documentation of institutional disclosures. The log will capture all relevant information about sentinel events that meet the institutional disclosure requirements in the VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*. The log will be maintained by the Patient Safety Manager. The Patient Safety Manager will review the log weekly at the QM huddle with the Planning/Performance Measurement/Performance Improvement (PI) Manager to ensure events requiring institutional disclosures are completed by the Executive Chief of Staff. The PI Manager will report Institutional Disclosure documentation, on a quarterly basis to the Clinical Executive Board (CEB). The Executive Chief of Staff is the CEB Chair. The CEB reports monthly to the Executive Council that is chaired by the System Director. The numerator will [be] the total number of sentinel events that have documented institutional disclosures. The denominator will be the total number of sentinel events identified that require an institutional disclosure. Compliance will be achieved when 90 percent of required institutional disclosures for sentinel events were completed within a six-month period.

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.⁴⁹ 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.⁵⁰

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.”⁵¹ “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.”⁵²

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
- Vaccine administration

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.

⁴⁹ “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>.

⁵⁰ VHA Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

⁵¹ 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). VA’s missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA’s fourth mission, the “[p]rovision of hospital care and medical services during certain disasters and emergencies...During and immediately following a disaster or emergency...VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency.”

⁵² VA OIG, *OIG Inspection of Veterans Health Administration’s COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.⁵³

⁵³ VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.⁵⁴ 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.⁵⁵ Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."⁵⁶

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."⁵⁷ 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."⁵⁸ 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

⁵⁴ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

⁵⁵ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

⁵⁶ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

⁵⁷ VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

⁵⁸ VHA Directive 1026.01.

Next, the OIG assessed the healthcare system’s processes for conducting protected peer reviews of clinical care.⁵⁹ 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.”⁶⁰ Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.⁶¹ 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 unit⁶²
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews⁶³
- Quarterly review of the Peer Review Committee’s summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the healthcare system’s surgical program. The VHA National Surgery Office provides oversight for surgical programs and “promotes systems and practices that enhance high quality, safe, and timely surgical care.”⁶⁴ The National Surgery Office’s principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include “(1) Operational oversight of surgical services and quality improvement activities; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select

⁵⁹ 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.”

⁶⁰ VHA Directive 1190.

⁶¹ VHA Directive 1190.

⁶² VHA Directive 1190.

⁶³ VHA Directive 1190. A peer review is assigned a Level 3 when “most experienced and competent clinicians would have managed the case differently.”

⁶⁴ “NSO Reporting, Resources, & Tools,” VA Surgical Quality Improvement Program, accessed November 21, 2020, <https://dvagov.sharepoint.com/sites/VHANSOVASQIP/SitePages/Default.aspx>. (This is an internal VA website not publicly accessible.)

specialty programs.”⁶⁵ The healthcare system’s performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events⁶⁶

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.⁶⁷

Quality, Safety, and Value Findings and Recommendations

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

VHA requires the System Director to ensure that staff complete final peer reviews within 120 calendar days from the determination that a peer review is needed or approve a written extension request.⁶⁸ The OIG determined that between June 2020 and March 2021, staff did not complete 8 of 30 peer review cases (27 percent) within 120 days or have a written extension signed by the Director. This potentially prevented timely actions to improve care. The Risk Manager and Planning Performance Measurement/Performance Improvement Manager stated that staff did not have access to hard copies of peer review documents while teleworking during the COVID-19 pandemic and could not determine which cases needed an extension.

Recommendation 3

3. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that staff complete final peer reviews within 120 calendar days or approves a written extension request.

⁶⁵ “NSO Reporting, Resources, & Tools.”

⁶⁶ VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

⁶⁷ For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

⁶⁸ VHA Directive 1190.

Healthcare system concurred.

Target date for completion: September 30, 2022

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. The Planning/Performance Measurement/Performance Improvement (PI) Manager established a Peer Review Share Point site for monitoring and tracking peer reviews from initiation to completion as well as maintaining Peer Review Committee meeting agendas and minutes. All members of the Peer Review Committee, the PI Manager, the Quality Management (QM) Program Analyst who reports to the PI Manager, clinical service chiefs, and their designees have access to the Share Point site. The Share Point site provides the ability to electronically monitor the timeliness of peer review completion. Weekly, the PI Manager will review the Share Point site and email service chiefs a list of pending peer reviews starting at day 20 of the 45-day process. The weekly service chief emails will include the Executive Chief of Staff. In addition, a tracking tool was developed by a QM Program Analyst to ensure that the 120-day timeliness requirement is met by the Peer Review Committee as well. The tracking tool includes all completed peer reviews and a 3-month rolling schedule of Peer Review Committee meeting dates to assist in the development of the monthly Peer Review Committee agenda which will ensure that the 120-day timelines are met. Monthly, the PI Manager will review the tracking tool and develop the agenda for the Peer Review Committee following the tracking tool schedule. The source document for all generated and tracked peer reviews is the VHA Risk Management Peer Review 2022 spreadsheet. Compliance will be achieved when 6 months of Peer Review Committee meeting minutes show 90 percent of peer reviews were completed and reviewed within 120 days. The numerator will be the total number of peer reviews completed within 120 days. The denominator will be the total number of peer reviews that required completion. The Peer Review Committee reports monthly to the Clinical Executive Board (CEB) that is chaired by the Executive Chief of Staff. The CEB reports monthly to the Executive Council that is chaired by the System Director.

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.”⁶⁹ 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.”⁷⁰

VA requires all RNs to hold at least one active, unencumbered license.⁷¹ 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.⁷² 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.⁷³ 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.⁷⁴

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 34 RNs hired from July 1, 2020, through May 26, 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 credentialing files for 30 of the 34 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

⁶⁹ VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (VHA Directive 2012-030 was replaced on September 15, 2021, by VHA Directive 1100.20, *Credentialing of Health Care Providers*. The two documents contain similar language regarding credentialing procedures.)

⁷⁰ VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

⁷¹ VHA Directive 2012-030, replaced by VHA Directive 1100.20. The two documents contain similar language regarding RN licenses. “Definition of *Unencumbered license*,” Law Insider, accessed December 3, 2020, <https://www.lawinsider.com/dictionary/unencumbered-license>. An unencumbered license is “a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action.”

⁷² 38 U.S.C. § 7402.

⁷³ VHA Directive 2012-030, replaced by VHA Directive 1100.20.

⁷⁴ VHA Directive 2012-030, replaced by VHA Directive 1100.20.

Registered Nurse Credentialing Findings and Recommendations

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

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.⁷⁵ The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.⁷⁶

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.⁷⁷ Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.⁷⁸

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."⁷⁹ The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.⁸⁰

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of 13 patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments
- Medication orders used proper name

⁷⁵ Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*, May 1, 2020, revised August 2020. Food and Drug Administration, "Frequently Asked Questions for Veklury (remdesivir)," updated February 4, 2021.

⁷⁶ Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

⁷⁷ Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*, May 8, 2020.

⁷⁸ Centers for Disease Control and Prevention, *Vaccine Storage and Handling Kit*, May 2014. "The cold chain begins with the cold storage unit at the manufacturing plant, extends through transport of vaccine(s) to the distributor, then delivery and storage at the provider facility, and ends with administration of vaccine to the patient. Appropriate storage conditions must be maintained at every link in the cold chain." Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*.

⁷⁹ Food and Drug Administration, "FDA News Release: COVID-19 Update: FDA Broadens Emergency Use Authorization for Veklury (remdesivir) to Include All Hospitalized Patients for Treatment of COVID-19," August 28, 2020.

⁸⁰ Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19," October 22, 2020.

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
 - Potential pregnancy
 - Kidney assessment (estimated glomerular filtration rate)⁸¹
 - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)⁸²
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the healthcare system addressed most of the indicators of expected performance, including staff availability to receive remdesivir shipments, proper naming for medication orders, staff determination that inclusion criteria were met, required testing completed prior to remdesivir administration, and adverse event reporting. However, the OIG identified a deficiency with patient or caregiver education prior to remdesivir administration.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*; inform patients or caregivers that remdesivir was not an FDA-approved medication; provide the option to refuse the medication; and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.⁸³ For the 13 patients who received remdesivir, the OIG determined that healthcare providers did not

- provide 92 percent of patients or caregivers with the *Fact Sheet for Patients and Parents/Caregivers*,
- inform 38 percent of patient or caregivers that remdesivir was not an FDA-approved medication,
- inform 15 percent of patients or caregivers of the option to refuse the treatment,

⁸¹ “Estimated Glomerular Filtration Rate (eGFR),” National Kidney Foundation, accessed December 9, 2020, <https://www.kidney.org/atoz/content/gfr>. “Estimated glomerular filtration rate [eGFR] is the best test to measure your level of kidney function and determine your stage of kidney disease.”

⁸² “Alanine transferase,” National Cancer Institute, accessed December 9, 2020, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/alanine-transferase>. Alanine transferase, also referred to as serum glutamate pyruvate transaminase, is “an enzyme found in the liver and other tissues,” of which a high level may be indicative of liver damage.

⁸³ VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

- advise 31 percent of patients or caregivers of the risks and benefits, or
- advise 46 percent of patients or caregivers of alternatives to receiving remdesivir prior to administration.⁸⁴

This could have resulted in the patient or caregiver lacking the information needed to make a fully informed decision to receive the medication. The Chief, Infectious Disease, Brooklyn and Chief, Pharmacy reported believing that providers educated patients and caregivers prior to administering remdesivir, despite their lack of documentation of each individual element in the electronic health record.

Given the FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.⁸⁵

⁸⁴ Confidence intervals are not included because the data represents every patient in the study population.

⁸⁵ Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19."

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.⁸⁶ The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.⁸⁷ However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.⁸⁸

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments (EDs) or urgent care centers (UCCs) begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.⁸⁹ The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the ED or UCC.⁹⁰ The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

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

To determine whether VHA facilities complied with selected requirements for suicide risk screening and evaluation within EDs and UCCs, the OIG inspection team interviewed key employees and reviewed

- relevant documents;

⁸⁶ “Suicide Prevention: Facts About Suicide,” Centers for Disease Control and Prevention, accessed October 8, 2021, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

⁸⁷ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.

⁸⁸ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.

⁸⁹ Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018; Department of Veterans Affairs, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting*, December 18, 2019.

⁹⁰ DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

- the electronic health records of 47 randomly selected patients who were seen in the ED/UCC from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

The healthcare system complied with requirements related to suicide prevention screening within EDs and UCCs. However, staff responsible for suicide safety plan development had not consistently completed the required training.

VHA requires staff to complete suicide safety plan training prior to developing suicide safety plans.⁹¹ The OIG found that 15 of 30 staff responsible for suicide safety plan development (50 percent) had not completed the mandatory training. The OIG also noted that the 15 staff who had not completed training were mental health providers who were not permanently assigned to the ED or UCC but responded to mental health consults as needed. Lack of training could prevent staff from providing optimal treatment to veterans who are at risk for suicide. The Associate Chief of Staff, Mental Health reported that safety plan training was automatically assigned to permanent ED and UCC staff and not to consulting providers. The chief also acknowledged changing the process so that training is assigned based on staff's clinical specialty rather than their specific work area.

Recommendation 4

4. The Executive Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that staff complete mandatory suicide safety plan training prior to developing suicide safety plans.

⁹¹ DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED Initiative)*.

Healthcare system concurred.

Target date for completion: October 31, 2022

Healthcare system response: The Executive Chief of Staff evaluated and determined no additional reasons for noncompliance. The Associate Chief of Staff (ACOS), Mental Health who is a service chief in the Clinical Services under the Executive Chief of Staff, provided a list of all currently employed staff who document suicide safety plans in the electronic health record to the acting Designated Learning Officer (DLO), a supervisor in the Education/Medical Media/Library Service under the Associate Director of Finance, on July 1, 2021. The acting DLO assigned Talent Management System (TMS) course VA-36232, Suicide Safety Planning Training to applicable staff. Current staff who had not been assigned the training were given a completion due date of 30 days after TMS assignment. The administrative officers for Mental Health at the Brooklyn and Manhattan campuses will notify the acting DLO of any new staff who need to be assigned TMS course VA-36232. The administrative officers report to the ACOS, Mental Health. New staff will be given 30 days to complete the training. The acting DLO will send bi-weekly reports of TMS training compliance to the ACOS, Mental Health. The ACOS, Mental Health will monitor the reports and follow up, sending emails to any non-compliant staff to ensure the required training is completed within 30 days. The numerator will be the total number of staff that completed the training prior to developing suicide safety plans and the denominator will be the total number of staff required to complete the TMS training. The goal will be 90 percent or greater compliance for six consecutive months. Compliance data will be reported monthly by the ACOS, Mental Health to the Mental Health Council. The Mental Health Council will report the compliance data quarterly to the Clinical Executive Board (CEB). The CEB is chaired by the Executive Chief of Staff.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.⁹²

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.”⁹³ 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.⁹⁴

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

- Existence of a system 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 34 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with requirements for monitoring and evaluating inter-facility transfers and nurse-to-nurse communication between facilities. However, the OIG identified deficiencies with completion of required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent note and transmission of an active medication list and

⁹² VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁹³ VHA Directive 1094.

⁹⁴ 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.

advance directive to the receiving facility. Both deficiencies are repeat findings from the 2017 OIG comprehensive healthcare inspection.⁹⁵

VHA requires the Chief of Staff and ADPS to ensure that appropriately privileged providers complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record prior to inter-facility patient transfers.⁹⁶ The OIG determined that for 24 percent of patient transfers, providers did not complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record prior to the transfer.⁹⁷ Additionally, the OIG found that providers did not document informed consent or medical and/or behavioral stability for 15 and 12 percent of patient transfers, respectively.⁹⁸

These deficiencies could result in the unsafe transfer of patients, the inability to accurately monitor and evaluate transfer data, and an incomplete medical record. The ED Chief, Manhattan attributed this to insufficient oversight of rotating providers who infrequently practiced within the healthcare system and reported believing that providers obtained informed consent but did not scan the paper document into the patients' electronic health records. Additionally, the ED Chief, Manhattan attributed missed documentation to providers not completing a templated transfer form.

Recommendation 5

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

⁹⁵ VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA New York Harbor Healthcare System, New York, New York*, Report No. 17-01762-88, February 7, 2018.

⁹⁶ VHA Directive 1094.

⁹⁷ Confidence intervals are not included because the data represents every patient in the study population.

⁹⁸ Confidence intervals are not included because the data represents every patient in the study population.

Healthcare system concurred.

Target date for completion: May 31, 2022

Healthcare system response: The Executive Chief of Staff and Associate Director, Patient Services evaluated and determined no additional reasons for noncompliance. The Emergency Department (ED) Chief at the Manhattan campus led an improvement team to improve compliance. The improvement team included the ED Chief from the Brooklyn campus. The ED chiefs are part of Clinical Services and report to the Executive Chief of Staff. The improvement team created a cognitive aid delineating the inter-facility transfer process, including all required documentation. The OIG findings and recommendations, baseline data for transfers during between April and June 2021, and the inter-facility transfer process were reviewed at the Clinical Executive Board (CEB) meeting on July 22, 2021. The inter-facility transfer process and cognitive aid were subsequently reviewed with the clinical service chiefs of inpatient services during the Clinical Services chiefs meeting on August 31, 2021. During that meeting, the required elements on the Inter-Facility Transfer Note (VA Inter-Facility Transfer Form 10-2649A) were also reviewed, including the requirement to send all pertinent medical records with the patient during the inter-facility transfer. The ED Chief, Manhattan subsequently reviewed the transfer process and all required elements at department level clinical service meetings that included attending physicians.

The Inter-Facility Transfer Note template was modified to require documentation of all required elements. The clinical applications coordinators, who report to the Executive Chief of Staff, ensured the modified template was available for use effective November 1, 2021.

The Inter-Facility Transfer Coordinator, who reports through the ED Chief, Manhattan, will monitor all inter-facility transfers for completion of all required elements for both the Brooklyn and Manhattan campuses. The Inter-Facility Transfer Coordinator will track all required inter-facility transfers elements on an Excel sheet that was revised in July 2021. The Inter-Facility Transfer Coordinator will provide immediate feedback by email to the responsible attending physician for any deficiencies and include a review of the required documentation and reshare the cognitive aid. The Inter-Facility Transfer Coordinator will forward the Excel tracking sheet to the ED Chief, Manhattan or designee who will review it on a weekly basis and submit any deficiencies to the responsible physician and service chief for review.

The Inter-facility Transfer Coordinator started auditing 100 percent of inter-facility transfer records for all required elements beginning July 2021, prior to review of the transfer process with the CEB and service chiefs, and prior to the implementation of the modified template. Audit results will be reported to Executive Chief of Staff on a quarterly basis, through the CEB meeting scheduled for the first month of the quarter. The Executive Chief of Staff chairs the CEB. The Associate Director, Patient Services is a member of the CEB.

The numerator will be the number of Inter-Facility Transfers Notes compliant for all required elements. The denominator will be the total number of patients who needed a completed Inter-Facility Transfer Note. Compliance will be achieved when monthly numerator/denominator audit results document 90 percent compliance for six months.

VHA requires that the Chief of Staff and ADPS ensure “all pertinent medical records available, including an active patient medication list and any medications given to the patient prior to transfer [be sent] with the patient, including documentation of the patient’s advance directive made prior to transfer, if any.”⁹⁹ The OIG determined that 4 of 28 applicable electronic health records (14 percent) lacked evidence that staff sent an active medication list to the receiving facility.¹⁰⁰ This could result in incorrect treatment decisions that potentially compromise patient safety. The Inter-facility Transfer Coordinator and Bed Flow Coordinator (Harbor) stated that all inpatient discharge and ED notes are routinely sent with patients during transfers and reported believing that staff sent notes containing the medication list but did not document it.

Furthermore, the OIG reviewed VHA’s Computerized Patient Record System and the Joint Legacy Viewer and found that five of eight electronic health records for patients who had advance directives (63 percent) lacked evidence that staff sent a copy to the receiving facility.¹⁰¹ This may have resulted in a lack of assurance that receiving facility staff could determine patient preferences regarding their health care immediately upon arrival should an emergency occur. The ED Chief, Manhattan reported that four electronic health records did not contain an advance directive within the Computerized Patient Record System, and that providers do not routinely check the Joint Legacy Viewer. The chief attributed noncompliance for the remaining instance to a lack of attention to detail. Due to the small number of patients identified for the medication list and advance directive requirements, the OIG made no recommendations.

⁹⁹ VHA Directive 1094.

¹⁰⁰ Confidence intervals are not included because the data represents every patient in the study population.

¹⁰¹ Confidence intervals are not included because the data represents every patient in the study population. Department of Veterans Affairs, *VISTA Computerized Patient Record System (CPRS): Clinician’s Getting Started Guide*, March 2005. The Computerized Patient Record System (CPRS) as “a Veterans Health Information Systems and Technology Architecture (VISTA) computer application” that enables the clinician “to enter, review, and continuously update all information connected with any patient.” Department of Veterans Affairs, Office of Information and Technology (OIT): *Joint Longitudinal View (JVL) 2.8, Deployment, Installation, Blackout, and Rollback (DIBR) Guide*, August 2019. The Joint Legacy Viewer as a “browser-based, graphical user interface (GUI) [that] provides an integrated, read only view of Electronic Health Record (EHR) data from the VA, DoD, and Veterans Health Information Exchange (VHIE) community partners, within a single application.”

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.”¹⁰² 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.”¹⁰³ 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 team¹⁰⁴
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings¹⁰⁵
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction¹⁰⁶
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants¹⁰⁷

¹⁰² VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

¹⁰³ VHA Directive 2012-026.

¹⁰⁴ 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.”

¹⁰⁵ 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.”

¹⁰⁶ 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.”

¹⁰⁷ 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.¹⁰⁸ VHA also requires that employee threat assessment team members complete the appropriate team-specific training.¹⁰⁹ The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The healthcare system complied with many of the administrative processes. However, the OIG found deficiencies with Disruptive Behavior Committee meeting attendance, Orders of Behavioral Restriction, and staff training.

VHA requires the Executive Chief of Staff and ADPS to establish a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; the patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the representative of the Union Safety Committee.¹¹⁰ The committee or board is responsible for coordinating with clinicians, recommending amendments to the patients' treatment plans that may reduce the patients' risk of violence, collecting and analyzing disruptive patient incidents, identifying system problems, and recommending to the Chief of Staff other actions related to the problem of patient violence.¹¹¹

The OIG found that from May 1, 2020, through April 30, 2021, a patient advocate or administrative support staff did not attend any of the five Disruptive Behavior Committee meetings.¹¹² Additionally, a VA police representative did not attend three of five meetings (60 percent). This could result in the committee taking a less comprehensive approach when assessing patients' disruptive behavior and carrying out other responsibilities. The Disruptive

¹⁰⁸ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMD) Training Assignments*, February 24, 2020.

¹⁰⁹ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

¹¹⁰ VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, corrected copy February 3, 2011.

¹¹¹ VHA Directive 2010-053.

¹¹² The Disruptive Behavior Committee reports to Environment of Care through the Security Management subcommittee.

Behavior Committee Chair reported being unaware of the VHA requirement because committee attendance was not reflected in the system's *Disruptive Behavior Prevention and Management Program* policy.

Recommendation 6

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

Healthcare system concurred.

Target date for completion: October 31, 2022

Healthcare system response: The Executive Chief of Staff and Associate Director, Patient Services evaluated and determined no additional reasons for noncompliance. A staff psychologist is the Disruptive Behavior Committee Chair (DBC). The psychologist reports to the Associate Chief of Staff (ACOS), Mental Health who is a service chief in the Clinical Services under the Executive Chief of Staff. The DBC Chair is responsible for monitoring required attendance at all DBC meetings. The DBC Chair developed and instituted an attendance sheet that will be used to monitor attendance at each DBC meeting. All DBC members will be reminded by email, prior to the meeting, of the meeting date and time and the requirement to attend the meeting. If DBC members do not attend the meeting, the DBC Chair will send a follow up email to the delinquent members requesting a reason for their lack of attendance and reminding the members of the need to attend future meetings. The DBC reports to the Workplace Violence Prevention Program Committee (WVPPC) that is chaired by a psychiatrist who serves as the Prevention and Management Disruptive Behavior Coordinator. The psychiatrist reports to the ACOS, Mental Health. In December 2021, the DBC Chair began monitoring and reporting monthly aggregate meeting attendance metrics to the WVPPC Chair. The numerator will be the total number of attendances by each required member and the denominator will be the total number of required members. Attendance metrics will be reported monthly until 90 percent compliance is sustained for six consecutive months. The attendance metrics will be reported monthly by the DBC Chair to the Mental Health Council. The Mental Health Council is chaired by the ACOS, Mental Health. The Mental Health Council will report compliance data quarterly to the Clinical Executive Board (CEB). The CEB is chaired by the Executive Chief of Staff. The Associate Director, Patient Services is a member of the CEB.

VHA requires the Executive Chief of Staff to ensure the Disruptive Behavior Committee documents the decision to implement an Order of Behavioral Restriction and the patient's notification of the order in the Disruptive Behavior Reporting System.¹¹³ The OIG determined there was no evidence that the committee documented the implementation and patient notification of Orders of Behavioral Restriction in the Disruptive Behavior Reporting System from May 1, 2020, through April 30, 2021. Failure to document in the Disruptive Behavior Reporting System may hinder staff's ability to consistently monitor and track all Order of Behavioral Restriction requirements. The Disruptive Behavior Committee Chair stated that committee members were unaware of the VHA requirement because they followed the healthcare system's policy, which was not consistent with VHA policy.

Recommendation 7

7. The Executive Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain the Disruptive Behavior Committee documents decisions to implement Orders of Behavioral Restriction and patients' notification of the orders in the Disruptive Behavior Reporting System.

¹¹³ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention (WVPP) Meet Agency Requirements*.

Healthcare system concurred.

Target date for completion: October 31, 2022

Healthcare system response: The Executive Chief of Staff evaluated and determined no additional reasons for noncompliance. The Disruptive Behavior Committee (DBC) Chair, a psychologist, and members have oversight for the patient flagging process. The psychologist reports to the Associate Chief of Staff (ACOS), Mental Health who is a service chief in the Clinical Services under the Executive Chief of Staff. All incidents submitted through the Disruptive Behavior Reporting System (DBRS) are reviewed by the DBC members and they decide which cases need a flag. The DBC Chair will notify the ACOS, Mental Health by email of all patients that require an Order of Behavioral Restriction (OBR) to be placed in the patient's electronic health record. The ACOS, Mental Health will then document the OBR in the DBRS. On a quarterly basis, the DBC Chair will monitor that all OBRs were entered in the DBRS. The DBC Chair will maintain a tracking spreadsheet of all OBRs to validate the DBRS data. The numerator will be the total number of patients who had an OBR entered into the DBRS and the denominator will be the total number of patients who need an OBR entered into the DBRS. The DBC Chair will submit a quarterly report of compliance through the Workplace Violence Prevention Program Committee to the Mental Health Council (chaired by the ACOS, Mental Health) until 90 percent compliance is sustained for 6 consecutive months. The Mental Health Council will report compliance data quarterly to the Clinical Executive Board (CEB). The CEB is chaired by the Executive Chief of Staff.

VHA requires that staff are assigned the Prevention and Management of Disruptive Behavior part 1 training at hire and "additional levels of PMDB [Prevention and Management of Disruptive Behavior] training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment."¹¹⁴ The OIG found that none of the 21 applicable staff completed part 2 training and none of the 8 applicable staff completed part 3. This could result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Disruptive Behavior Committee Chair reported that Prevention and Management of Disruptive Behavior training parts 2 and 3 remain cancelled since the beginning of the COVID-19 pandemic due to the social distancing requirement. Additionally, the chair acknowledged deciding not to adopt the online class option because of the one-to-six trainer-to-trainee ratio.

¹¹⁴ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*; DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

Recommendation 8

8. 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.¹¹⁵

Healthcare system concurred.

Target date for completion: March 1, 2023

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. Level 2 and level 3 in person Prevention and Management of Disruptive Behavior (PMDB) training was suspended for the past 2 years due to COVID-19 social distancing restrictions and the shortage of PMDB trainers due to staff being detailed to support the COVID-19 response or out on sick leave due to COVID-19 infection. The system will resume level 2 and level 3 PMDB face-to-face training on April 1, 2022, pending no additional COVID infection surges. The PMDB Coordinator, a staff psychiatrist who reports to the ACOS, Mental Health and the acting Designated Learning Officer (DLO), a supervisor in the Education/Medical Media/Library Service under the Associate Director of Finance are responsible for ensuring PMDB trainings are completed as assigned. The number of staff requiring level 2 and level 3 in person training will be identified by the acting DLO and assigned training according to the risk level. The PMDB Coordinator will establish a schedule of training dates and make those dates available by email to staff who require the training. The PMDB Coordinator and acting DLO will coordinate with service chiefs to schedule and remind staff by email to attend the PMDB training. Additional PMDB trainers will be recruited to support PMDB training needs by the PMDB Coordinator through presentations at the system level Director's Staff Conference held on March 16, 2022, and the COVID Moving Forward Team meeting on March 31, 2022, to support PMDB training needs.

The numerator will be the number of assigned staff who have completed the level 2 and level 3 training. The denominator will be the total number of staff who are required to complete the level 2 and level 3 training. The PMDB Coordinator, in coordination with the DLO, will monitor level 2 and level 3 training compliance and report data quarterly to the Mental Health Council until 90 percent compliance is sustained for six consecutive months. The Mental Health Council is chaired by the ACOS, Mental Health. The Mental Health Council reports quarterly to the Clinical Executive Board (CEB). The CEB is chaired by the Executive Chief of Staff. The CEB reports monthly to the Executive Council that is chaired by the System Director.

¹¹⁵ The OIG recognizes that COVID-19 has affected facility operations and makes no comment on the timeline for safely accomplishing this important 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 eight clinical and administrative areas and provided eight recommendations on systemic issues that may adversely affect patients. While the OIG's recommendations are not a comprehensive assessment of the caliber of services delivered at this healthcare system, they illuminate areas of concern and provide a road map for improvement. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines eight OIG recommendations aimed at improving vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the System Director, Executive Chief of Staff, and ADPS. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> Executive leadership position stability and engagement Budget and operations Staffing Employee satisfaction Patient experience Accreditation surveys and oversight inspections Identified factors related to possible lapses in care and healthcare system response VHA performance data (healthcare system) VHA performance data (CLC) 	<ul style="list-style-type: none"> Leaders identify adverse events as sentinel events when criteria are met. Leaders conduct institutional disclosures for all sentinel events. 	<ul style="list-style-type: none"> None
COVID-19 Pandemic Readiness and Response	<ul style="list-style-type: none"> Emergency preparedness Supplies, equipment, and infrastructure Staffing Access to care CLC patient care and operations Staff feedback Vaccine administration 	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this 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	<ul style="list-style-type: none"> QSV committee Systems redesign and improvement Protected peer reviews Surgical program 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Staff complete final peer reviews within 120 calendar days and any extensions are approved in writing by the System Director.
RN Credentialing	<ul style="list-style-type: none"> RN licensure requirements Primary source verification 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> None
Medication Management: Remdesivir Use in VHA	<ul style="list-style-type: none"> Staff availability for medication shipment receipt Medication order naming Satisfaction of inclusion criteria prior to medication administration Required testing prior to medication administration Patient/caregiver education Adverse event reporting to the FDA 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	<ul style="list-style-type: none"> Columbia-Suicide Severity Rating Scale initiation and note completion Suicide safety plan completion Staff training requirements 	<ul style="list-style-type: none"> Staff complete mandatory suicide safety plan training prior to developing suicide safety plans. 	<ul style="list-style-type: none"> None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	<ul style="list-style-type: none"> • Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities 	<ul style="list-style-type: none"> • Appropriately privileged providers complete all elements of the VA <i>Inter-Facility Transfer Form</i> or a facility-defined equivalent note in the electronic health record prior to patient transfers. 	<ul style="list-style-type: none"> • None
High-Risk Processes: Management of Disruptive and Violent Behavior	<ul style="list-style-type: none"> • Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training 	<ul style="list-style-type: none"> • The Disruptive Behavior Committee documents decisions to implement Orders of Behavioral Restriction and patients' notification of the orders in the Disruptive Behavior Reporting System. 	<ul style="list-style-type: none"> • All 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.

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1a) affiliated healthcare system reporting to VISN 2.¹

**Table B.1. Profile for VA NY Harbor Healthcare System (630)
(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	\$729,726,876	\$763,946,446	\$747,223,777
Number of:			
• Unique patients	48,310	48,155	45,119
• Outpatient visits	727,873	715,437	631,399
• Unique employees§	2,926	2,890	2,851
Type and number of operating beds:			
• Community living center	179	179	179
• Domiciliary	66	66	66
• Intermediate	20	20	20
• Medicine	77	77	77
• Mental health	46	42	42
• Rehabilitation medicine	8	8	8
• Surgery	51	24	24

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 “1a” indicates a facility with “high volume, high risk patients, most complex clinical programs, and large research and teaching programs.” An affiliated healthcare system is associated with a medical residency program.

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
Average daily census:			
• Community living center	107	138	125
• Domiciliary	49	53	30
• Intermediate	8	7	5
• Medicine	59	59	57
• Mental health	37	32	22
• Rehabilitation medicine	2	1	1
• Surgery	17	15	12

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

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

*October 1, 2017, through September 30, 2018.

†October 1, 2018, through September 30, 2019.

‡October 1, 2019, through September 30, 2020.

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Harlem, NY	630GA	623	342	–	–	Social work
Staten Island, NY	630GB	2,233	1,728	Endocrinology Eye Podiatry	–	Nutrition Pharmacy Social work Weight management

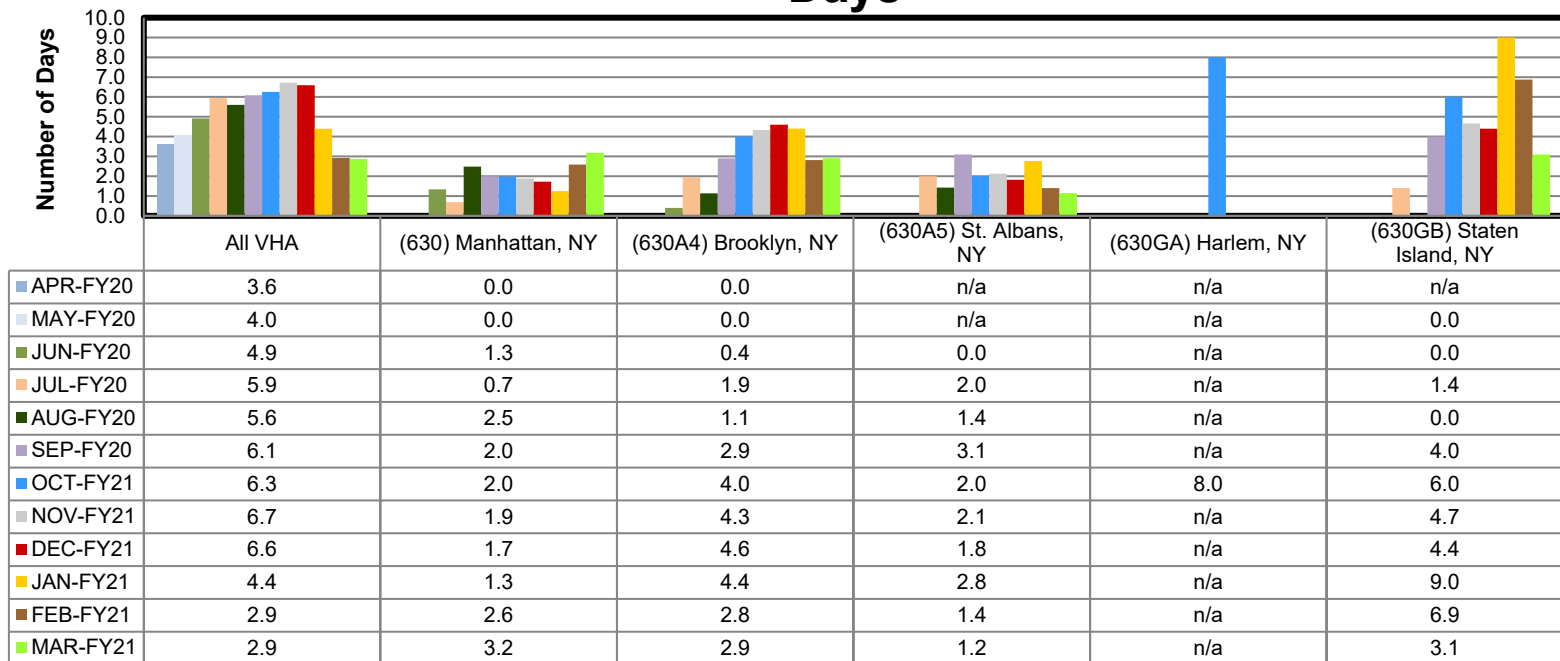
Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

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.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

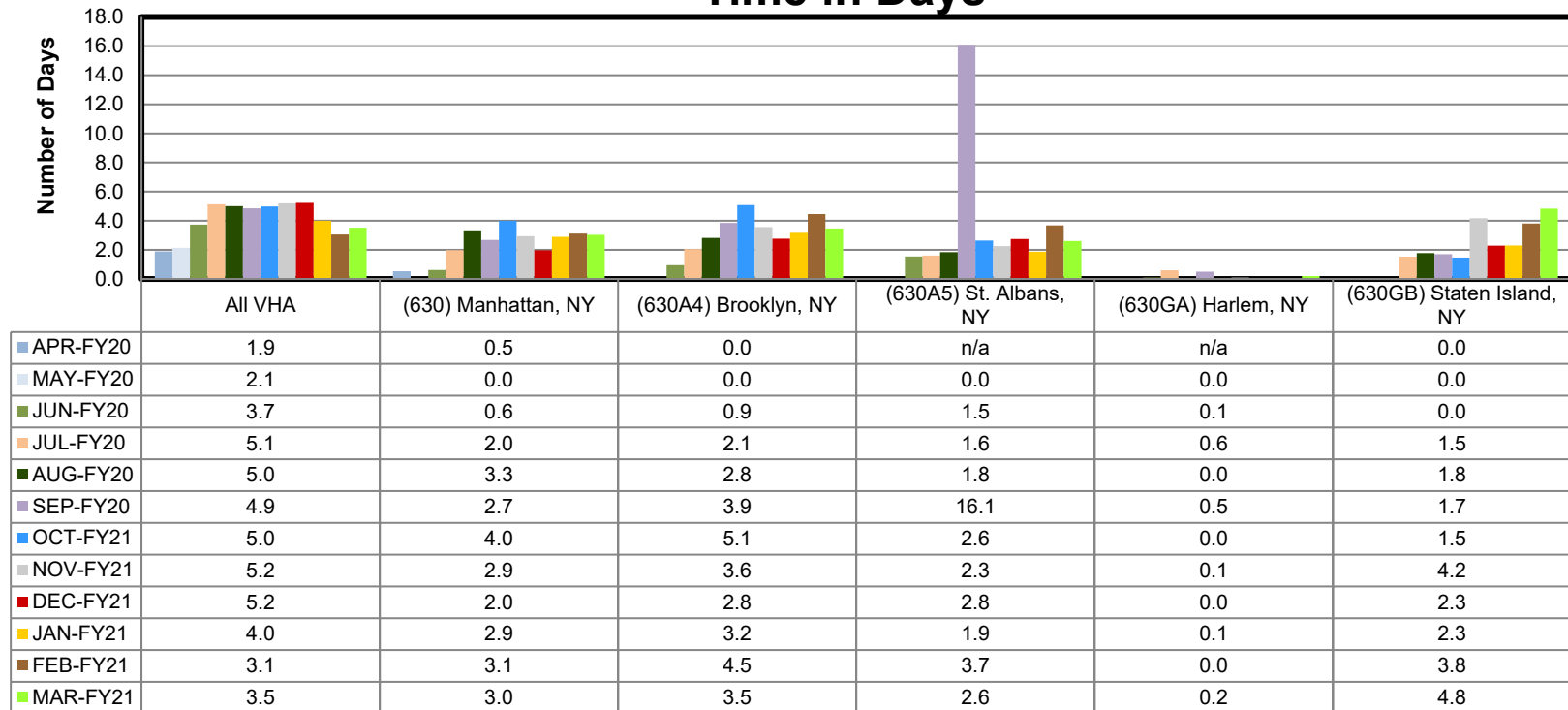


Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, <https://vssc.med.va.gov>, accessed October 21, 2019. (This is an internal website not publicly accessible.)

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

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

Quarterly Established Primary Care Patient Average Wait Time in Days



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

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

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

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use engmt	Sharing and use of All Employee Survey (AES) data	A higher value is better than a lower value
Behavioral health (BH90)	Healthcare Effectiveness Data and Information Set (HEDIS) outpatient performance measure composite related to screening for depression, posttraumatic stress disorder, alcohol misuse, and suicide risk	A higher value is better than a lower value
Care transition (HCAHPS)	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
Diabetes (DMG90_ec)	HEDIS outpatient performance measure composite for diabetes care	A higher value is better than a lower value
ED throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Healthcare associated infections	A lower value is better than a higher value
Hospital rating (HCAHPS)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Inpt global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	A higher value is better than a lower value

Measure	Definition	Desired Direction
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH population coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	Care coordination (PCMH)	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care (SC) providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH survey)	A higher value is better than a lower value

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

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 25, 2022

From: Director, VA Healthcare Network Upstate New York (10N2)

Subj: Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York.

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

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

Thank you for the opportunity to review the OIG draft report, Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York. I concur with the report findings, recommendations, and corrective action plans submitted.

(Original signed by:)

Joan E. McInerney, MD, MBA, MA, FACEP
Network Director, VISN 2

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: April 25, 2022

From: Director, VA NY Harbor Healthcare System (630/00)

Subj: Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York.

To: Director, VA Healthcare Network Upstate New York (10N2)

1. I have reviewed the draft report – Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York. I concur with the findings and recommendations.
2. I appreciate the opportunity for this review as a continuing process to improve the care to our Veterans.

(Original signed by:)

Bruce A. Tucker, LCSW
Interim Director

OIG Contact and Staff Acknowledgments

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