DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Northport VA Medical Center in New York

CHIP REPORT | **REPORT #21-00300-130** | **MAY 5, 2022**

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Figure 1. *Northport VA Medical Center in New York.*
Source: https://www.va.gov/northport-health-care/locations/ (accessed April 21, 2022).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Northport VA Medical Center and multiple 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 response[1]
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)
5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
6. Care coordination (spotlighting inter-facility transfers)
7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual inspection of the Northport VA Medical Center during the week of July 12, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help this medical center and other Veterans Health Administration (VHA) facilities identify

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

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

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued five recommendations to the Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the medical center's executive leadership team consisted of the Medical Center Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. The executive team had worked together for almost five months. The Director and Associate Director for Patient Care Services were the most tenured leaders, having been appointed in July and September 2019, respectively. These leaders monitored patient safety and care through the Quality Safety and Value Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Governance Board.

The OIG reviewed employee satisfaction survey results and found medical center averages for the selected survey leadership questions were mostly similar to or lower than VHA averages. Scores related to the Director were consistently higher than those for VHA and the medical center; however, the team noted opportunities for leaders to decrease employees' feelings of moral distress at work.[2]

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences in inpatient and outpatient settings. Overall, outpatient satisfaction survey results generally reflected higher care ratings than VHA averages. Gender-specific survey results indicated that both male and female respondents were satisfied with their primary care experiences compared to Veterans Health Administration patients nationally; however, female respondents appeared less satisfied with their specialty care.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.[3] The executive leaders were

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

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

knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to poor performance on specific SAIL measures. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[4]

Quality, Safety, and Value

The medical center complied with most of the requirements for quality, safety, and value, including committee oversight functions, processes for the Systems Redesign and Improvement Program, assignment and duties of the Chief of Surgery, and a surgical work group that regularly tracks and reviews surgical program metrics. However, the OIG identified a deficiency in protected peer reviews.[5]

Registered Nurse Credentialing

The OIG reviewers found that registered nurses hired from July 1, 2020, through June 13, 2021, were free from potentially disqualifying licensure actions. However, the OIG found deficiencies in the primary source verification process.

Medication Management

The OIG found the medical center addressed many of the indicators of expected performance, including staff availability to receive medication shipments, staff determination that patients met criteria for receiving the medication prior to administration, and required testing completed prior to remdesivir administration. However, the OIG found deficiencies with the provision of patient/caregiver education.

[4] 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.

[5] 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.

Care Coordination

The OIG observed general compliance with requirements for completion of the VA *Inter-Facility Transfer Form* or facility-defined equivalent.[6] However, the OIG identified deficiencies with transmission of patients' advance directives to the receiving facility and nurse-to-nurse communication between sending and receiving facilities.

High-Risk Processes

The medical center met many of the requirements for the management of disruptive and violent behavior, including implementation of the Employee Threat Assessment Team and Disruptive Behavior Committee, use of the Disruptive Behavior Reporting System, and completion of the Workplace Behavioral Risk Assessment. However, the OIG identified deficiencies with consistent attendance at Disruptive Behavior Committee meetings and completion of prevention and management of disruptive behavior training.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued five recommendations for improvement to the Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use these recommendations to help guide improvements in operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

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

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 62–63, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

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

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

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual 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 response[5]
3. Quality, safety, and value (QSV)
4. Registered nurse (RN) 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. 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)

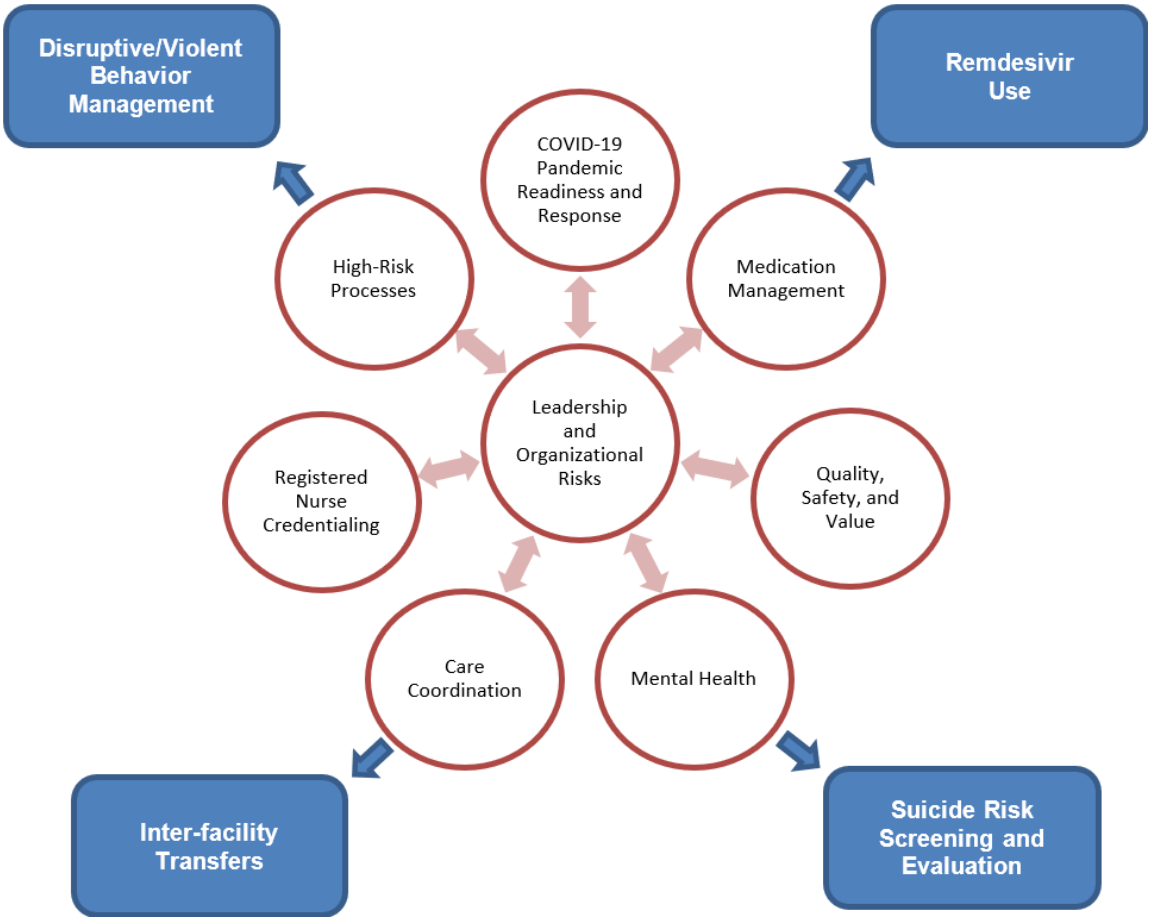


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

The Northport VA Medical Center also provides care through multiple outpatient clinics in New York. Additional details about the types of care provided by the medical center can be found in appendixes B and C.

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

The inspection examined operations from April 23, 2018, through July 16, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[8]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[9] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the medical center response
8. VHA performance data (medical center)
9. VHA performance data (community living center (CLC))[11]

Executive Leadership Position Stability and Engagement

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

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

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

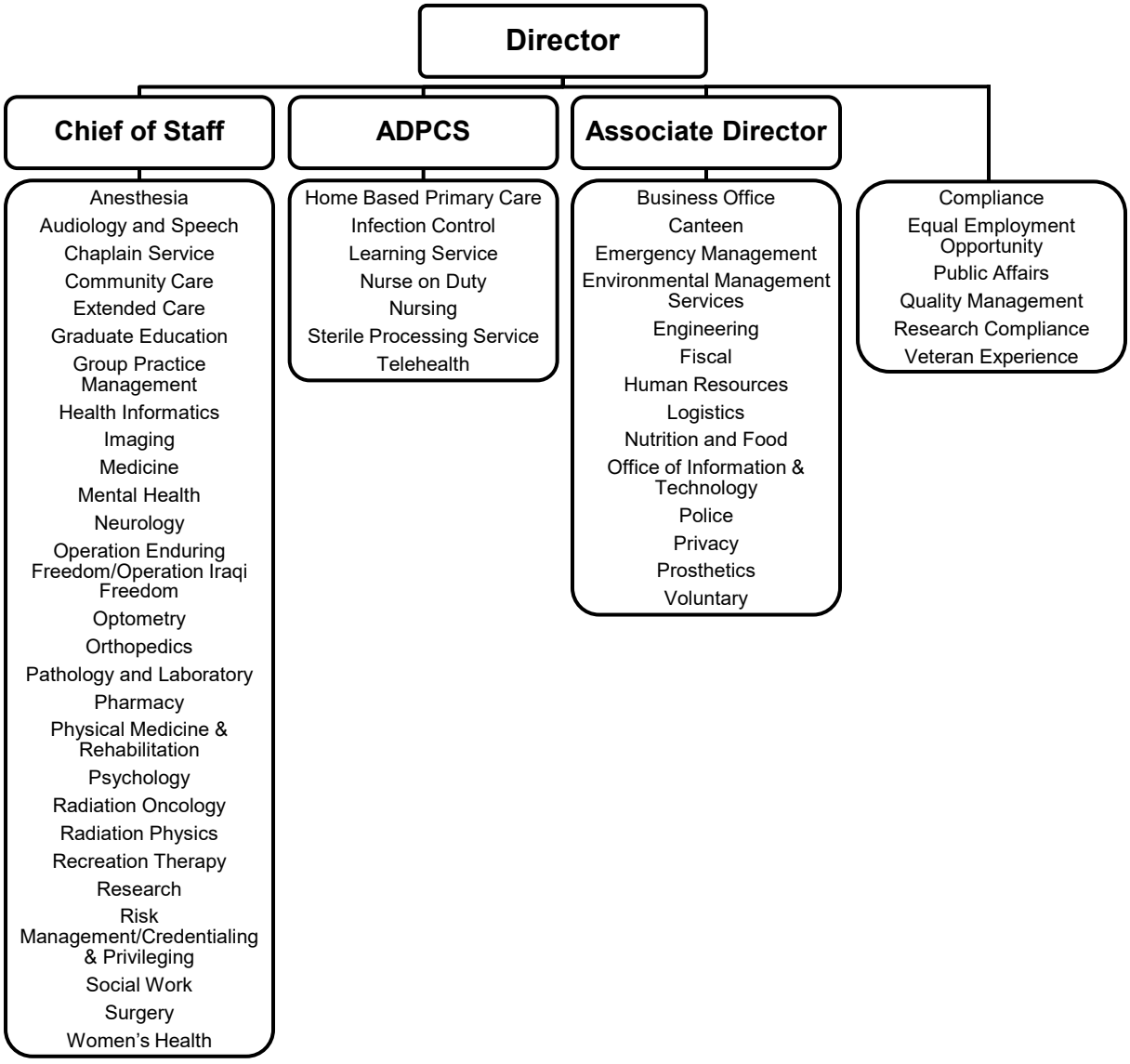


Figure 3. *Medical center organizational chart.*

Source: Northport VA Medical Center (received July 12, 2021).

At the time of the OIG inspection, the executive team had worked together for almost five months. The Director and ADPCS had the longest tenures in their positions, since July and September 2019, respectively (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	July 21, 2019
Chief of Staff	December 8, 2019
Associate Director for Patient Care Services	September 29, 2019
Associate Director	February 28, 2021 (acting); May 9, 2021 (permanent)

Source: Northport VA Medical Center Senior Strategic Business Partner (received July 13, 2021).

The Director served as the chairperson of the Executive Governance Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Governance Board oversaw working groups such as the Operations, Quality Safety and Value, Clinical Executive, Education, and Nurse Executive Councils. These leaders monitored patient safety and care through the Quality Safety and Value Council, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

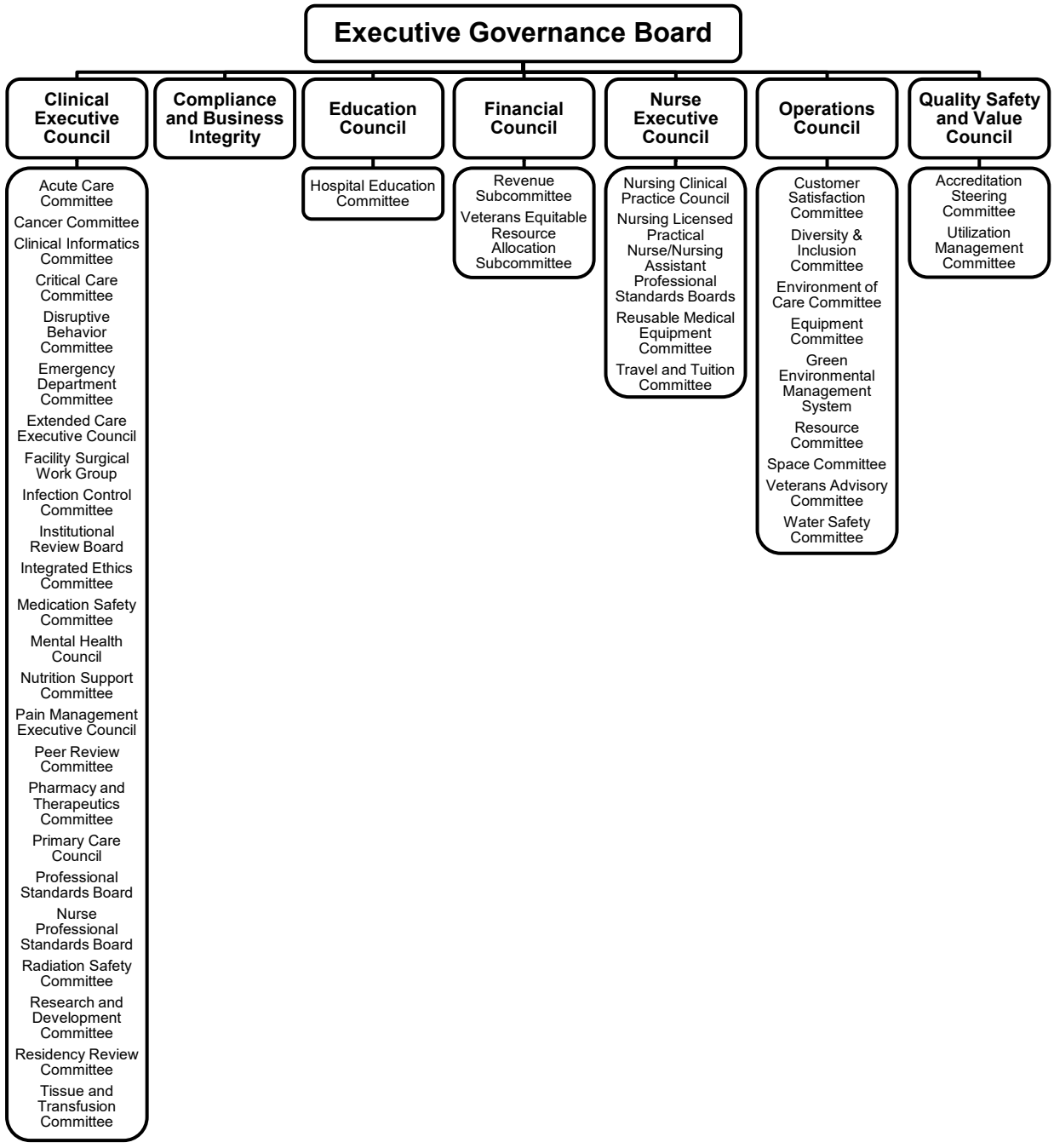


Figure 4. *Medical Center committee reporting structure.*

Source: Northport VA Medical Center (received July 12, 2021).

To help assess the medical center executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational

performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The medical center's FY 2020 annual medical care budget of $407,810,264 increased by 14 percent compared to the previous year's budget of $357,253,786.[12] When asked about the effect of this change on the medical center's operations, the Director indicated that increased funding supported overtime costs and equipment purchases.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[13] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[14] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[15]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[16] At the time of the OIG inspection, executive leaders confirmed that occupations listed in table 2 generally remained the top clinical and nonclinical occupational shortages. The ADPCS commented that the Environmental Management Service had experienced a top nonclinical occupation shortage since the start of the pandemic with the increased need for cleaning and disinfecting.

The executive team described ongoing efforts to address occupational shortages that included reviewing market pay adjustments and offering available incentives such as the Education Debt Reduction Plan.[17] The ADPCS and Associate Director spoke of competing with multiple

[12] VHA Support Service Center.

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

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

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

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

[17] "VA Careers: Hiring Programs and Initiatives," Department of Veterans Affairs, accessed November 29, 2021, https://www.vacareers.va.gov/Benefits/HiringProgramsInitiatives. The "Education Debt Reduction Program (EDRP) authorizes VA to provide student loan reduction payments to employees with qualifying loans who are in positions providing direct patient care and that are considered hard to recruit or retain."

hospitals in the area for staff, and according to the ADPCS, community hospitals were hiring faster than VHA. The ADPCS also described offering staff overtime pay and cross-training to work in high-need areas as interim strategies to alleviate stresses caused by occupational shortages.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Nursing Assistant	1. Medical Support Assistance
2. RN Staff Nurse-Inpatient	2. Food Service Worker
3. Practical Nurse	3. Medical Records Technician
4. Diagnostic Radiologic Technologist	4. Medical Supply Aide and Technician
5. RN/Staff-Inpatient Community Living Center	5. Engineering Technician

Source: VA OIG.

Employee Satisfaction

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

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[20] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. The OIG found the medical center averages for the selected survey leadership questions were mostly similar to or lower than the VHA averages.[21] Scores related to the Director were consistently higher than those for VHA and the medical center. However, the

[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, Chief of Staff, ADPCS, and Associate Director.

[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.

scores reflected opportunities for the Associate Director to improve employee attitudes toward medical center leaders.[22]

The Chief of Staff, ADPCS, and Associate Director had served in various positions at the facility for many years prior to joining the executive leadership team, and these leaders described how veterans and staff knew them and were comfortable approaching them with questions, comments, or concerns.

The Director spoke of the need to change the perception of the facility because employees and veterans judged the medical center based on past experiences. The Director reported working to improve communication and transparency with veterans and staff. Additionally, the Director discussed visiting each community-based outpatient clinic quarterly and described how a status report on the clinics was added to the medical center's morning meeting so leaders could take action to resolve any reported issues.

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	75.1	92.7	81.8	81.7	56.7
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.3	4.2	3.5	3.3	3.0
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	4.3	3.6	3.4	3.0
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.5	4.3	3.6	3.5	3.1

Source: VA All Employee Survey (accessed June 14, 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 medical center averages for the selected survey questions were similar to the VHA averages. Scores related to the Director were consistently better than those for VHA and the medical center. However, opportunities appeared to exist for the Associate Director to improve employee attitudes toward the workplace and for leaders to reduce employees' feelings

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

of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	4.6	4.0	3.8	3.4
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.0	4.1	3.9	3.4
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.4	1.1	1.6	1.3	1.7

Source: VA All Employee Survey (accessed June 14, 2021).

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

The leaders described efforts to support a harassment-free environment and demonstrate commitment to a culture of safety, and the leadership team publicly signed the "Stand Up to Stop Harassment Now!" campaign declaration.[26] Staff created posters of the signed declaration and educational material and stationed them in high-traffic areas throughout the medical center and community-based outpatient clinics. Leaders stated that staff conduct investigations and follow up with needed actions for all concerns related to harassment and discrimination.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The medical center averages for the selected survey questions were similar to the VHA averages. Scores for the Director, Chief of Staff, and ADPCS were similar to or higher than VHA and medical center averages. Opportunities existed for the Associate Director to improve employee perceptions related to respect and discrimination.

[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	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.4	4.3	4.0	3.5
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.1	4.3	4.2	4.1	3.8
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.3	4.2	4.0	3.5

Source: VA All Employee Survey (accessed June 14, 2021).

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, 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 medical center.[27] Overall, for this medical center, patient satisfaction survey results generally reflected similar or higher care ratings than VHA averages.

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

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	67.6
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	87.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	89.1

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[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). For the Inpatient survey, results for male respondents were lower than the corresponding VHA averages, while those for female respondents were higher. Patient-Centered Medical Home survey results for male respondents were similar to or higher than the corresponding VHA averages, and female respondents' scores were consistently more positive than those for female VHA patients nationally. Specialty care survey scores for male respondents were higher than those for VHA nationally, while female scores were less favorable than corresponding averages.

[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.

The Associate Director discussed challenges with aging infrastructure, plumbing, and a previously leaking roof. Leaders also reported working with the Army Corps of Engineers to remove two old buildings by summer 2021, which would create space for an additional parking lot by the following year.

The Chief of Staff and ADPCS described communication-enhancing improvements made to the inpatient environment that included a new call system, provision of individualized information for veterans during their hospital stay, and an "End of Visit" card with discharge instructions. The Chief of Staff also stated that the Environmental Management Service team made many efforts to ensure inpatient units were clean.

The Chief of Staff explained that the medical center only had a male gynecologist, and the provider referred women for community care when a female gynecologist was requested. Because feedback from forums and other patient comments showed women's preference to receive gynecologic care at the medical center, the Chief of Staff reported plans to hire fee-based female providers to deliver in-house care. Additionally, the Director discussed holding focus groups for women veterans, and based on feedback from these groups, instructed staff to ask female veterans their preference for a male or female provider when scheduling appointments.

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

Questions	Scoring	VHA*		Medical Center †	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	66.1	99.2
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	83.3	100.0
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	84.1	100.0

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

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

†*The medical center averages are based on 317–324 male and 12 female respondents, depending on the question.*

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	49.5	69.6
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	61.2	61.8
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	77.8	85.8

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

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

†*The medical center averages are based on 398–1,471 male and 24–43 female respondents, depending on the question.*

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	55.4	45.0
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	61.4	50.2
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	77.4	67.5

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

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

†*The medical center averages are based on 414–1,055 male and 17–30 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 medical center inspections most recently performed by the OIG and The Joint Commission (TJC). At the time of the virtual inspection, the OIG team noted that all

[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."

recommendations had been closed.[30] The team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and College of American Pathologists.[31] Additional results included the Long Term Care Institute's inspection of the CLC.[32]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Alleged Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York*, Report No. 17-03347-290, September 18, 2018)	June and August 2017	9	0
OIG (*Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center, New York*, Report No. 17-03347-285, September 18, 2018)	October 2017	3	0
OIG (*Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York*, Report No. 17-03347-293, September 18, 2018)	October 2017	3	0

[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] 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.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Northport VA Medical Center, New York*, Report No. 18-01018-281, September 18, 2018)	April 2018	11	0
TJC Hospital Accreditation	May 2018	37	0
TJC Behavioral Health Care Accreditation		6	0
TJC Home Care Accreditation		2	0
TJC Laboratory Services	May 2021	3	0

Source: OIG and TJC (inspection/survey results received from the Regulatory Specialist on July 14, 2021).

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

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

Table 11 lists the reported patient safety events from April 23, 2018 (the prior OIG CHIP site visit), to July 12, 2021.[33]

[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 Northport VA Medical Center is a mid-high complexity (1c) affiliated medical center as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

Table 11. Summary of Selected Organizational Risk Factors (April 23, 2018, to July 12, 2021)

Factor	Number of Occurrences
Sentinel Events	6
Institutional Disclosures	9
Large-Scale Disclosures	0

Source: Northport VA Medical Center, Assistant Chief of Quality Management (received July 12 and 15, 2021).

The Director reported being informed of serious adverse patient events through various avenues, including from front line employees and frequent meetings with the Patient Safety Officer. The Director was able to speak knowledgeably about the progress or status of actions to improve the quality and safety of care, including implementation, outcomes monitoring, and action item closure. Discussion with the Director revealed a collaborative decision-making process to determine when an institutional disclosure was warranted. Collaboration occurred with the Chief of Staff; quality management staff; and when the event involved nurses, the ADPCS.

Veterans Health Administration Performance Data for the Medical Center

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]

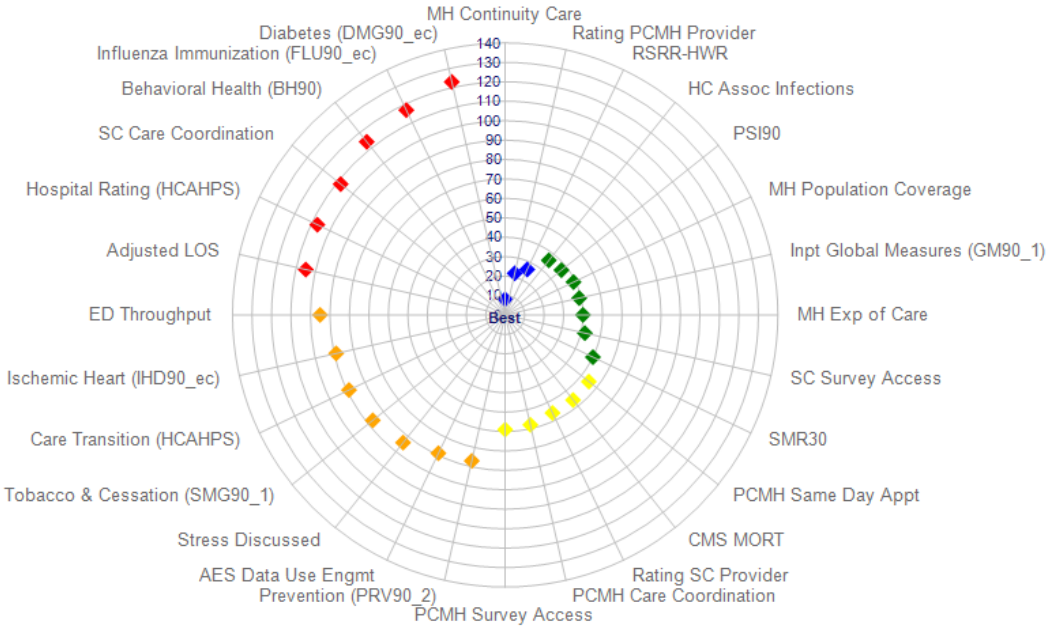
Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, mental health (MH) continuity (of) care, rating (of) patient-centered medical home (PCMH) provider, and health care (HC) associated (assoc) infections). Metrics in the fourth and fifth quintiles are those

[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."

that need improvement and are denoted in orange and red, respectively (for example, stress discussed, adjusted length of stay (LOS), and specialty care (SC) care coordination).[36]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures. The leaders verbalized understanding of specific SAIL measures that needed improvement and explained actions taken to address poorly performing areas.



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 5. *Medical Center quality of care and efficiency metric rankings (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 the performance of CLCs in the VA."[37] The model "leverages much of the same data" used in the Centers for Medicare &

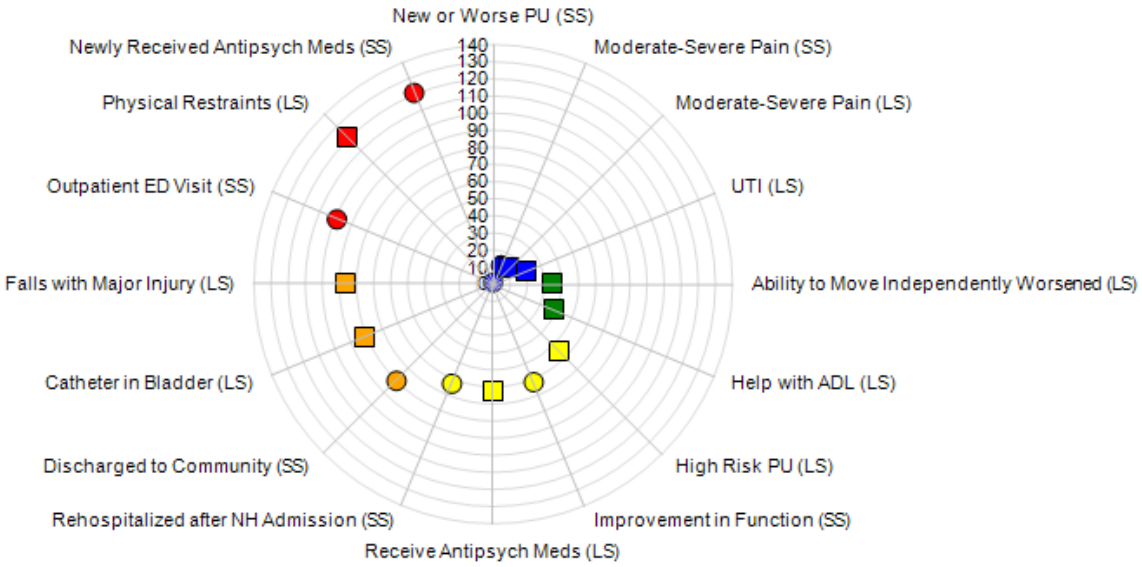
[36] For information on the acronyms in the SAIL metrics, please see appendix E.

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[38]

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. Figure 6 displays the metrics with high performance (blue and green data points) in the first and second quintiles (for example, new or worse pressure ulcer (PU)–short-stay (SS), urinary tract infection (UTI)–long-stay (LS), and help with activities of daily living (ADL) (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, discharged to community (SS), falls with major injury (LS), and physical restraints (LS)).[39]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poorly performing CLC SAIL measures. Leaders spoke in depth about actions taken to maintain or improve performance.



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 6. *Northport CLC quality measure rankings (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.

[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*. "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."

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

Leadership and Organizational Risks Findings and Recommendations

The executive team had worked together for almost five months at the time of the OIG's virtual inspection. The Director and ADPCS were the most tenured leaders, appointed in July and September 2019, respectively. These leaders monitored patient safety and care through the Quality Safety and Value Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Governance Board.

The OIG reviewed employee satisfaction survey results and found the medical center averages for the selected survey leadership questions were mostly similar to or lower than VHA averages. Scores related to the Director were consistently higher than the VHA and the medical center averages; however, the team noted opportunities for leaders to reduce employees' feelings of moral distress at work.

The OIG also reviewed selected responses to several relevant questions that reflect patients' experiences in inpatient and outpatient settings. Overall, outpatient satisfaction survey results generally reflected similar or higher care ratings than VHA averages. Gender-specific survey results indicated that both male and female respondents were satisfied with their primary care experiences compared to VHA patients nationally; however, female respondents appeared less satisfied with their specialty care.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to poor performance on specific VHA performance measures. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[40] 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.[41]

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."[42] "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."[43]

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

- Emergency preparedness
- Supplies, equipment, and infrastructure
- Staffing
- Access to care
- CLC patient care and operations
- Vaccine administration

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

[40] "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.

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

[42] 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."

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

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[44]

[44] 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.[45] 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.[46] 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."[47]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center's committee responsible for quality, safety, and value (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 medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[48] 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."[49] 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

[45] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[46] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[47] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence.*
[48] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.
[49] VHA Directive 1026.01.

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[50] 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."[51] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[52] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[53]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[54]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[55] 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;

[50] 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."

[51] VHA Directive 1190.

[52] VHA Directive 1190.

[53] VHA Directive 1190.

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

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[56] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (RN)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[57]

The OIG reviewers interviewed program 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.[58]

Quality, Safety, and Value Findings and Recommendations

The OIG found the medical center complied with most of the requirements for QSV, including committee oversight functions, processes for the Systems Redesign and Improvement Program, assignment and duties of the Chief of Surgery, and a surgical work group that regularly tracks and reviews surgical program metrics. However, the OIG identified a deficiency in protected peer reviews.

VHA requires peer reviews for all deaths "within 24 hours of admission (except in cases when death is anticipated and clearly documented, such as transfer from hospice care)."[59] The OIG found that from July 2020 through June 2021, staff did not conduct peer reviews for two applicable deaths that occurred within 24 hours of admission. This may have prevented timely identification of issues in the practice of one or more healthcare providers within the medical center. The Risk Manager reported screening the two deaths that occurred within 24 hours of admission but did not believe they warranted peer review. The Chief of Staff stated that for both cases, the initial reviewer examined circumstances surrounding the day of admission but had not reviewed the prior episodes of care.

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

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

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

[59] VHA Directive 1190.

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that staff conduct a peer review for all applicable deaths that occur within 24 hours of admission.

Medical Center concurred.

Target date for completion: September 1, 2022

Medical Center response: Northport has a tracking system in place for monitoring and reviewing deaths within 24 hours of admission. The Assistant Quality Management Chief and Risk Manager are responsible to ensure these reviews are completed timely and reviewed for peer review appropriateness. A report is generated daily for all inpatient deaths, and this includes death within 24 hours of admission. These mortality reviews are documented on a spreadsheet and stored on the Quality share drive. All deaths within 24 hours, with the exception of cases in which death is anticipated and clearly documented, are sent for peer review. The number of deaths within 24 hours of admissions and the number reviewed for peer review appropriateness are documented on a spreadsheet and reported out at Quality Safety and Value (QSV) Council on a monthly basis.

Expected Compliance: The Quality Management Risk Manager will monitor compliance and report to the QSV Council monthly until 90% is sustained for six consecutive months. Data collection will be from March 2022 to August 2022. The Chief of Staff is a member of QSV Council.

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."[60] 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."[61]

VA requires all RNs to hold at least one active, unencumbered license.[62] 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.[63] 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.[64] 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.[65]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and staff and reviewing relevant documents for 27 RNs hired from July 1, 2020, through June 13, 2021. The OIG determined whether

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

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

---

[60] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (This directive 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.)

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

[62] 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."

[63] 38 U.S.C. § 7402.

[64] VHA Directive 2012-030, replaced by VHA Directive 1100.20.

[65] VHA Directive 2012-030, replaced by VHA Directive 1100.20.

Registered Nurse Credentialing Findings and Recommendations

The OIG found that registered nurses hired from July 1, 2020, through June 13, 2021, were free from potentially disqualifying licensure actions. However, the OIG found deficiencies in the primary source verification process.

VHA requires the Medical Center Director to ensure that "all licenses including not only current licenses, but all previously held, must be verified through primary source verification," which "must be completed at the time of initial application."[66] The OIG found that 6 of 27 RNs' credentialing files reviewed lacked documentation of primary source verification for each license held. Failure to verify each nursing license hinders the assurance that all RNs at the medical center are qualified to provide care. The OIG noted that RN applicants did not consistently report all licenses or former names. The Human Resources Specialist Employee Labor Relations, who was the only staff person assigned to credential dependent providers for the period reviewed, explained being unaware of the requirement to use the Nursys database to search for nursing applicants' previously held licenses and former names. The specialist also reported inconsistently using the database until November 2020, when informed by VISN peers of the OIG's credentialing review. The Chief of Staff described obstacles in meeting the staffing requirements to support credentialing processes, including having inflexible position descriptions, receiving hiring certifications that contained applicants for other VA facilities, and difficulty recruiting for the medical center's physical location and credentialers in general.

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that credentialing staff complete primary source verification of all registered nurses' licenses at the time of initial application.

[66] VHA Directive 2012-030, replaced by VHA Directive 1100.20.

Medical Center concurred.

Target date for completion: September 1, 2022

Medical Center response: A retrospective review was conducted of all active/current RNs at Northport VAMC [Veterans Affairs Medical Center] and all licenses in VetPro were verified, updated if necessary, and matched to the Nursys website. Credentialing & Privileging (C&P) department's credentialing staff began the audit beginning August 2021 and completed in December 2021.

Expected Compliance: C&P Program Specialist and Risk Manager will monitor compliance of RN license verification and report to the Quality Safety and Value (QSV) Council monthly until 90% is sustained for six consecutive months. Data collection will be from March 2022 to August 2022 as a continuation of the retrospective audit done using same tool already used. The Chief of Staff is a member of QSV Council.

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[67] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[68]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[69] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[70]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[71] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[72]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of four 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

---

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

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

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

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

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

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

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
  - Potential pregnancy
  - Kidney assessment (estimated glomerular filtration rate)[73]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[74]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the medical center addressed many of the indicators of expected performance, including staff availability to receive medication shipments, staff determination that patients met criteria for receiving the medication prior to administration, and required testing completed prior to remdesivir administration. However, the OIG found deficiencies with the provision of patient/caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, inform patients and/or caregivers that remdesivir was not an FDA-approved medication prior to the administration, provide the option to refuse the medication, and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[75] For the four patients who received remdesivir, the OIG determined that healthcare providers did not

- provide the *Fact Sheet for Patients and Patients/Caregivers* to any of the patients or caregivers (100 percent);
- inform three patients or caregivers (75 percent) that remdesivir was not an FDA-approved medication; or

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

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

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

- advise two patients or caregivers (50 percent) of the known risks, benefits, and alternatives to receiving remdesivir prior to administration.

This could have resulted in patients or caregivers lacking the information needed to make a fully informed decision to receive the medication. The Chief of Medicine and Associate Chief Pharmacy Service reported not being aware of the patient/caregiver handout, and therefore, not giving it to patients. The Chiefs of Medicine and Infectious Diseases also stated that they believed providers discussed the information with the patients or caregivers but did not document the full conversation 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.[76]

[76] 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.[77] 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.[78] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[79]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[80] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[81] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

[80] 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.

[81] 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 50 randomly selected patients who were seen in the emergency department or urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[82]

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."[83] 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.[84]

The medical center was assessed for its adherence to various requirements:

- Existence of a facility policy for inter-facility transfers
- Monitoring and evaluation of inter-facility transfers
- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer
- Transmission of patient's active medication list and advance directive to the receiving facility
- Communication between nurses at sending and receiving facilities

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed managers and key employees. The team also reviewed the electronic health records of 50 patients who were transferred from the medical center due to urgent care 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 completion of the VA *Inter-Facility Transfer Form* or facility-defined equivalent. However, the OIG identified deficiencies with transmission of patients' advance directives to the receiving facility and nurse-to-nurse communication between sending and receiving facilities.

---

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

[83] VHA Directive 1094.

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

VHA requires the Chief of Staff and ADPCS to ensure that transferring physicians or assigned designees "send all pertinent medical records available, including…documentation of the patient's advance directive made prior to transfer, if any" to the receiving facility.[85] The OIG found that 11 electronic health records for patients who had an advanced directive lacked evidence that staff sent a copy to the receiving facility. As a result, there was no assurance that receiving facility staff could determine the patient's healthcare preferences should an emergent situation arise. An emergency department physician stated that there were four full-time physicians and additional medical staff who intermittently provided care in the emergency department, and attributed noncompliance to those providers who worked less frequently. Due to the low number of patients identified for this review element, the OIG made no recommendation.

Additionally, VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at both the sending and receiving facilities.[86] The OIG did not find evidence of this communication for an estimated 86 percent of inter-facility transfers (95% CI: 75.56 and 95.13 percent), which is statistically significantly above the 10 percent deficiency benchmark. This could result in receiving staff lacking the information needed to provide continuity of care for patients. The Emergency Department Nurse Manager stated that the nurses communicated with the paramedic conducting the transfer, and they believed this met the requirement.

Recommendation 3

3. The Associate Director for Patient Care Services determines any additional reasons for noncompliance and ensures nurse-to-nurse communication occurs between sending and receiving facilities.

[85] VHA Directive 1094.

[86] VHA Directive 1094.

Medical Center concurred.

Target date for completion: September 1, 2022

Medical Center response: The ADPCS will ensure oversight of nurse-to-nurse communication between sending and receiving facilities. The sending nurse must document in the Discharge/Handoff transfer note the last name and title of the receiving nurse, or designated nurse, taking the report in the receiving facility. Nurse-on-Duty (NOD), Bed Board Manager, and/or Nurse Manager of transferring facility will ensure Nurse-to-Nurse handoff is documented accurately in CPRS [Computerized Patient Record System] in real-time. The Med/Surg Associate Chief Nurse Service, or designee, will review 100% of transfers and conduct audits daily to validate that nurse-to-nurse communication has been documented in the transfer record. Transfers and on-going audit compliance information will be shared daily on the Clinical Morning report.

Expected Compliance: Interfacility Transfers have been regularly reported monthly at Quality Safety and Value (QSV) Council. The report includes an additional focus on the nurse-to-nurse handoff monitoring and compliance which will continue until 90% compliance is sustained for six consecutive months. Data collection will be from March 2022 to August 2022. The ADPCS is a member of QSV Council.

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."[87] 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."[88] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[89]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[90]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[91]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[92]

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

[88] VHA Directive 2012-026.

[89] 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."

[90] 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."

[91] 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."

[92] DUSHOM Memorandum, *Workplace Behavioral Risk Assessment (WBRA)*, October 19, 2012. The Workplace Behavioral Risk Assessment is a "data-driven process that evaluates the unique constellation of factors that affect workplace safety. It enables facilities to make informed, supportable decisions regarding the level of PMDB [Prevention and Management of Disruptive Behavior] training needed to sustain a culture of safety in the workplace."

VHA requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[93] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[94] 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 medical center generally complied with requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with consistent attendance at Disruptive Behavior Committee meetings and completion of prevention and management of disruptive behavior training.

VHA requires facilities' clinical executives (Chief of Staff and ADPCS) to establish a disruptive behavior committee or board that includes a senior clinician chairperson; clerical and administrative support staff; a patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, patient safety and/or risk management, VA police, and Union Safety Committee.[95] The committee or board is responsible for coordinating with clinicians, recommending amendments to patients' treatment plans that may reduce their 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.[96]

The OIG reviewed Disruptive Behavior Committee attendance for 12 meetings held from November 16, 2020, through June 21, 2021, and the committee charter and found that clerical and administrative support staff did not attend any meetings and were not listed as members on

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

[94] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

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

[96] VHA Directive 2010-053.

the charter.[97] This could affect the committee members' ability to effectively monitor and track information related to patients' disruptive behavior. The Disruptive Behavior Committee chair and Chief of Psychology acknowledged being aware that clerical and administrative staff were required members but had not yet sought support to have representatives assigned.

Recommendation 4

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

Medical Center concurred.

Target date for completion: September 1, 2022

Medical Center response: The Chief of Staff evaluated the reasons for non-compliance and determined there were no additional reasons for non-compliance. The Chair and Co-Chair of the DBC (Disruptive Behavior Committee) are responsible for monitoring core members or their designated representatives' attendance at all scheduled DBC meetings and implement corrective actions when core members or alternate representatives do not attend scheduled meetings. The DBC membership roster was revised to include administrative support as a core member to support tracking attendance. DBC Chair and Co-Chair assigned alternate members to use them as back-up designees in the event the member cannot attend the meeting. All alternates were provided with training to perform as a primary member for the committee. Chair and Co-Chair will ensure that core members/alternate are invited to all scheduled meetings and will maintain a record of attendance in each monthly meeting minutes.

Expected Compliance: The Chair and Co-Chair of the DBC will monitor attendance data and report to the Quality Safety and Value (QSV) Council monthly until 90% attendance is sustained for six consecutive months. Data collection will be from March 2022 to August 2022. The Chief of Staff and Associate Director for Patient Care Services are members of QSV Council.

VHA requires employees to complete prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[98] The OIG found that 25 of 30 employees (83 percent) had not completed required trainings. This could result in employees' lack of awareness, preparedness, and precautions when responding to disruptive

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

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

behavior. The Director of Learning Systems stated that in-person trainings remained suspended due to the pandemic, affecting completion of required training.

Recommendation 5

5. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[99]

Medical Center concurred.

Target date for completion: September 1, 2022

Medical Center response: In January 2022, Disruptive Behavior Committee (DBC) Chair reviewed the facility's Prevention and Management of Disruptive Behavior (PMDB) training records and found that 98.42% of the staff received Level 1, 90.40% Level 2 low, 0% Level 2 mod/high, and 0% Level 3 training for the past 12 months. Level 2 mod/high and Level 3 in-person training was suspended for the past 20 months due to COVID-19 social distancing restrictions and the shortage of PMDB trainers due to staff detailed to support the COVID-19 response.

The facility will resume Level 2 mod/high and Level 3 PMDB training starting 04/01/2022. The DBC Chair and the Talent Management System (TMS) Coordinator are responsible for implementing actions to ensure PMDB training is completed as assigned. The number of staff that require Level 2 mod/high and Level 3 in-person (4-hours) training have been identified and assigned training according to risk level. PMDB trainers will provide at least one training day a week to meet the facility's PMDB Program staff training needs.

Expected Compliance: The Chair of the DBC, in coordination with the TMS Coordinator, will monitor PMDB level 1, 2 and 3 training compliance and report data to the Quality Safety and Value (QSV) Council monthly until 90% training compliance is sustained for six consecutive months. Data collection will be from March 2022 to August 2022. The Medical Center Director is a member of the QSV Council.

[99] 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 medical center, the OIG conducted a detailed review of eight clinical and administrative areas and provided five recommendations on issues that may adversely affect patients. While the OIG's recommendations are not a comprehensive assessment of the caliber of services delivered at this medical center, they illuminate areas of concern and guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines five OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Medical Center Director, Chief of Staff, and ADPCS. The intent is for these leaders to use the recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Budget and operations • Staffing • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Identified factors related to possible lapses in care and medical center response • VHA performance data (medical center) • VHA performance data (CLC)	• None	• None
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback • Vaccine administration	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• Staff conduct a peer review for all applicable deaths that occur within 24 hours of admission.	• None
RN Credentialing	• RN licensure requirements • Primary source verification	• Credentialing staff complete primary source verification of all registered nurses' licenses at the time of initial application.	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None

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

Appendix B: Medical Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated medical center reporting to VISN 2.[1]

Table B.1. Profile for Northport VA Medical Center (632)
(October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
Total medical care budget	$352,611,661	$357,253,786	$407,810,264
Number of:			
• Unique patients	30,092	29,747	28,161
• Outpatient visits	403,592	403,963	352,243
• Unique employees§	1,494	1,494	1,464
Type and number of operating beds:			
• Community living center	170	170	170
• Domiciliary	38	38	38
• Intermediate	19	19	19
• Medicine	80	80	80
• Mental health	42	42	42
• Rehabilitation medicine	8	4	4
• Surgery	24	6	6

[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) VHA medical centers are classified according to a facility complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." An affiliated medical center is associated with a medical residency program.

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019 †	Medical Center Data FY 2020‡
Average daily census:			
• Community living center	107	170	129
• Domiciliary	35	40	24
• Intermediate	1	0	0
• Medicine	20	24	21
• Mental health	24	34	32
• Rehabilitation medicine	4	2	–
• Surgery	4	4	3

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

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
East Meadow, NY	632GA	6,749	1,441	Dermatology Gastroenterology General surgery Neurology Podiatry	–	Nutrition Pharmacy Weight management
Valley Stream, NY	632HA	1,277	795		–	Weight management

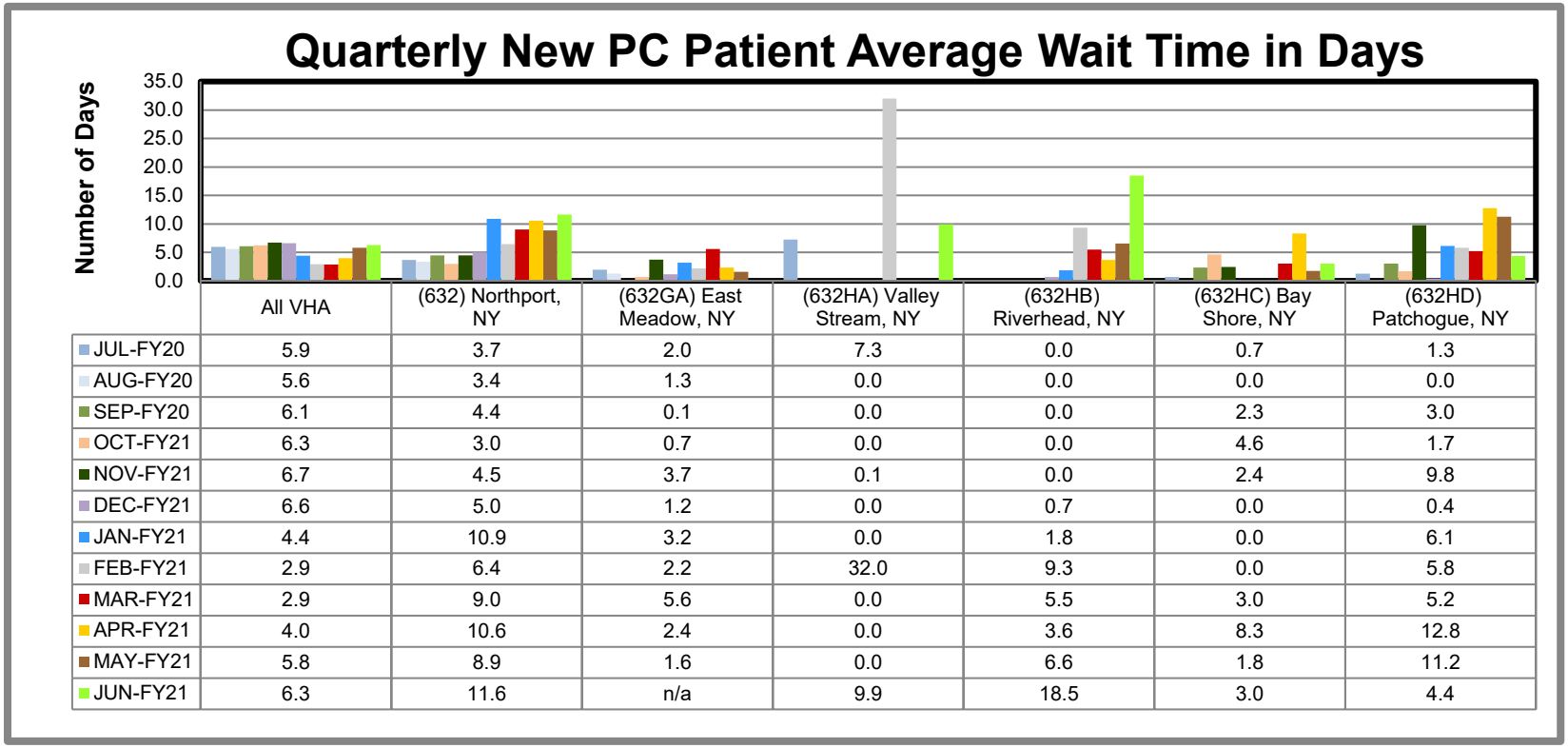
[1] VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a "professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition." Specialty care services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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Riverhead, NY	632HB	2,580	981	Dermatology Endocrinology Gastroenterology General surgery Nephrology Neurology Otolaryngology Podiatry Rehabilitation physician Vascular	–	Weight management
Bay Shore, NY	632HC	1,561	1,303	–	–	Weight management
Patchogue, NY	632HD	4,199	445	Dermatology Endocrinology Gastroenterology Nephrology Neurology	–	Nutrition Pharmacy Weight management

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

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

Appendix D: Patient Aligned Care Team Compass Metrics



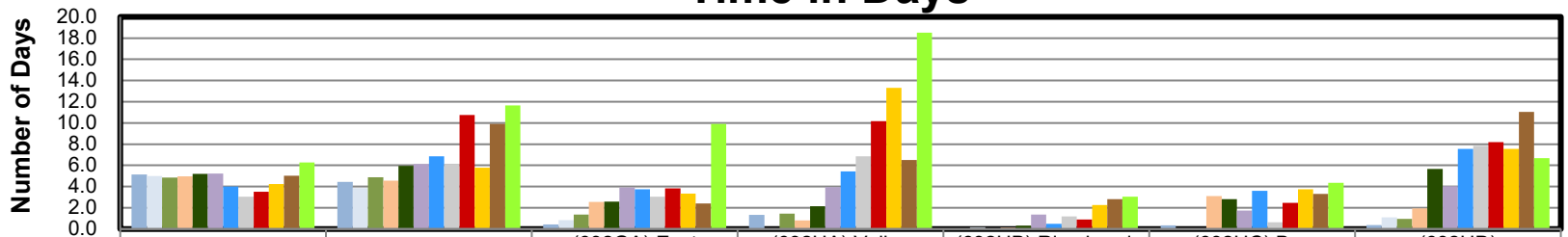
	All VHA	(632) Northport, NY	(632GA) East Meadow, NY	(632HA) Valley Stream, NY	(632HB) Riverhead, NY	(632HC) Bay Shore, NY	(632HD) Patchogue, NY
JUL-FY20	5.9	3.7	2.0	7.3	0.0	0.7	1.3
AUG-FY20	5.6	3.4	1.3	0.0	0.0	0.0	0.0
SEP-FY20	6.1	4.4	0.1	0.0	0.0	2.3	3.0
OCT-FY21	6.3	3.0	0.7	0.0	0.0	4.6	1.7
NOV-FY21	6.7	4.5	3.7	0.1	0.0	2.4	9.8
DEC-FY21	6.6	5.0	1.2	0.0	0.7	0.0	0.4
JAN-FY21	4.4	10.9	3.2	0.0	1.8	0.0	6.1
FEB-FY21	2.9	6.4	2.2	32.0	9.3	0.0	5.8
MAR-FY21	2.9	9.0	5.6	0.0	5.5	3.0	5.2
APR-FY21	4.0	10.6	2.4	0.0	3.6	8.3	12.8
MAY-FY21	5.8	8.9	1.6	0.0	6.6	1.8	11.2
JUN-FY21	6.3	11.6	n/a	9.9	18.5	3.0	4.4

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the medical center's explanation for the increased wait times for the Valley Stream community-based outpatient clinic.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	All VHA	(632) Northport, NY	(632GA) East Meadow, NY	(632HA) Valley Stream, NY	(632HB) Riverhead, NY	(632HC) Bay Shore, NY	(632HD) Patchogue, NY
JUL-FY20	5.1	4.4	0.4	1.3	0.1	0.4	0.4
AUG-FY20	5.0	3.9	0.8	0.0	0.2	0.0	1.1
SEP-FY20	4.9	4.9	1.4	1.4	0.1	0.0	1.0
OCT-FY21	5.0	4.6	2.6	0.8	0.2	3.1	1.9
NOV-FY21	5.2	5.9	2.6	2.2	0.3	2.8	5.7
DEC-FY21	5.2	6.1	3.9	3.9	1.4	1.8	4.0
JAN-FY21	4.0	6.8	3.8	5.4	0.5	3.6	7.6
FEB-FY21	3.1	6.1	3.0	6.9	1.2	0.6	7.8
MAR-FY21	3.5	10.7	3.8	10.2	0.9	2.5	8.2
APR-FY21	4.3	5.8	3.3	13.3	2.3	3.7	7.6
MAY-FY21	5.0	9.9	2.4	6.5	2.8	3.3	11.0
JUN-FY21	6.3	11.6	9.9	18.5	3.0	4.4	6.7

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

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

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

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

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

Measure	Definition	Desired Direction
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH population coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	Care coordination (PCMH)	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care 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: March 15, 2022

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subj: Comprehensive Healthcare Inspection of the Northport VA Medical Center in New York

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

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 Northport VA Medical Center in New York. I concur with the report findings, recommendations and the submitted action plans.

(Original signed by:)

Joan E. McInerney, MD, MBA, MA, FACEP

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: March 11, 2022

From: Director, Northport VA Medical Center (632/00)

Subj: Comprehensive Healthcare Inspection of the Northport VA Medical Center in New York

To: Director, New York/New Jersey VA Health Care Network (10N2)

1. I have reviewed the findings within the Comprehensive Healthcare Inspection of the Northport VA Medical Center. The Northport VAMC concurs with the outcome of the inspection and recommendations provided. The corrective action plan and target dates have been established and I have complete confidence that the plans will be effective.

2. Thanks you for the opportunity to respond to this report and strengthen the care of our Veterans.

(Original signed by:)

Antonio Sanchez, MD, MHSA, FAPA, FACHE

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Kristie Van Gaalen BSN, RN, Team Leader Erin Allman, MSN, RN Keri Burgy, MSN, RN Kimberley De La Cerda, MSN, RN Janice Fleming, DNP, RN Donna Murray, MSN, RN Elizabeth K. Whidden, MS, APRN Michelle Wilt, MBA, BSN
Other Contributors	Melinda Alegria, AUD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH Robert Wallace, ScD, MPH

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 2: New York/New Jersey VA Health Care Network
Director, Northport VA Medical Center (632/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kirsten Gillibrand, Charles Schumer
U.S. House of Representatives: Yvette Clarke, Andrew Garbarino, Hakeem Jeffries, Nicole Malliotakis, Gregory Meeks, Grace Meng, Jerry Nadler, Kathleen Rice, Thomas Suozzi, Nydia Velázquez, Lee Zeldin

OIG reports are available at www.va.gov/oig.