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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

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Figure 1. *Brooklyn VA Medical Center of the VA NY Harbor Healthcare System in New York.*

Source: https://www.va.gov/new-york-harbor-health-care/locations/ (*accessed January 20, 2023*).

Abbreviations

ADPS	Associate Director Patient Services
CHIP	Comprehensive Healthcare Inspection Program
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA NY Harbor Healthcare System, which includes three medical centers located in Brooklyn, Manhattan, and Queens and two outpatient clinics in New York.[1] The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

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

The OIG initiated an unannounced inspection of the VA NY Harbor Healthcare System during the week of December 5, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued 12 recommendations to the Director, Deputy Medical Center Director, and Executive Chief of Staff in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; Environment of Care; and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for leaders to use recommendations as a road map to help

[1] The three locations are the Brooklyn VA Medical Center, the Margaret Cochran Corbin VA campus in Manhattan, and the St. Albans VA Medical Center in Queens.

improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 29.

VA Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 33–34, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

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

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

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

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

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

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014): 13, https://doi.org/10.1136/bmjopen-2014-005055.

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

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

Methodology

The VA NY Harbor Healthcare System includes three medical centers located in Brooklyn, Manhattan, and Queens and two outpatient clinics in New York.[5] General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review beginning Monday, December 5, 2022.[6] Following the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline for further review.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[7] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

[5] The three locations are the Brooklyn VA Medical Center, the Margaret Cochran Corbin VA campus in Manhattan, and the St. Albans VA Medical Center in Queens.

[6] The OIG's last comprehensive healthcare inspection of the VA NY Harbor Healthcare System concluded in July 2021. The Joint Commission performed a behavioral health care and human services review in January 2021 and hospital, behavioral health care and human services, and home care accreditation reviews in July 2021.

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

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[8] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[9] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[10]

To assess this healthcare system's leadership and risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director, Deputy Medical Center Director, Executive Chief of Staff, Associate Director Patient Services (ADPS), Associate Director/Finance, and Associate Director/Facilities. The Executive Chief of Staff and ADPS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for approximately 11 months and included three temporarily assigned leaders. The former Director retired in December 2021, and an Interim Director was in the position through December 2022. The Interim Director reported a permanent Director had been selected with a tentative start date in

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

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

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

January 2023. The deputy medical center director position, which was established in January 2021, had one interim staff member in the role since January 2022.

The former Executive Chief of Staff was temporarily assigned to a position with the VA Central Office in January 2022 and permanently selected for that role in March 2022. The two Deputy Chiefs of Staff rotated monthly to cover the executive chief of staff position beginning in January 2022. The Interim Director reported reviewing potential candidates for the position but stated the new Director would make the selection. The Associate Directors had system-wide organizational responsibilities, and each had oversite of a specific campus.

To help assess executive leaders' engagement, the OIG interviewed the Interim Director, Interim Deputy Medical Center Director, Acting Executive Chief of Staff, ADPS, and Associate Director/Finance regarding their knowledge, involvement, and support of actions to improve or sustain performance.[11]

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $806,956,087 decreased by approximately 1 percent compared to the previous year's budget of $812,434,384.[12] The system's overall patient visits decreased from FY 2021 to 2022, but the average daily hospital census increased. The Interim Director related these changes to the COVID-19 pandemic and stated the budget was adequate. Despite the budget decrease, the Associate Director/Finance reported sufficient funds for various projects including a new heating, air conditioning, and ventilation system; roof; cooling and chilling towers; information technology equipment; as well as renovations to the operating room and a portion of the inpatient mental health unit.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation

[11] The Associate Director/Facilities was unavailable during the week of the inspection.

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

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

without fear of reprisal.[14] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The system's scores for the selected question were lower than VHA for all three years. The leaders conveyed that the plan for improving All Employee Survey scores included frequent communication through the Interim Director's weekly messages, daily huddles, and increased presence in patient care areas. The ADPS described how the daily tiered huddle process, in which employees at similar levels met to discuss and address problems, resulted in enhanced information sharing and staff empowerment. The ADPS explained that by the time executive leaders met, staff had typically already resolved most issues. The Interim Director concurred that this process provided front-line staff the opportunity to identify and solve problems prior to leaders' involvement.

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

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
VA NY Harbor Healthcare System	3.7	3.8	3.8

Source: VA All Employee Survey (updated October 31, 2022).

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

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from October 2019 through July 2022. Table 2 provides survey results for VHA and the healthcare system over time.

Inpatient scores were consistently lower than VHA averages, but primary and specialty care scores were generally higher. The Interim Deputy Medical Center Director explained that many staff retired or left employment due to the pandemic and acknowledged difficulty navigating recent human resources process changes. The ADPS added that competition from other area hospitals that were actively recruiting presented challenges with hiring and retaining employees

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

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

and described efforts to attract nursing staff through benefits and a new residency program. The Acting Executive Chief of Staff detailed steps taken to improve the inpatient experience such as forming an interdisciplinary work group focused on the discharge process, providing inpatients with paper and pens to document questions to ask their providers prior to discharge, and updating the patient resource guide.

Table 2. Survey of Healthcare Experiences of Patients (October 2019 through July 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	62.9	69.7	63.2	68.5	58.4
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	82.5	83.7	81.9	84.2	81.0	82.7
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	88.6	83.3	81.1	82.0	84.0

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 7, 2022).

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

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[16] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[17] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[18]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[19] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[20] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives that they may have been affected by an adverse event resulting from a systems issue."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[22]

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[16] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[17] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, accessed January 8, 2023, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

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

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

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

[21] VHA Directive 1004.08.

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

The Patient Safety Manager explained how staff reported adverse events through the Joint Patient Safety Reporting system.[23] The Patient Safety Manager then reviewed them with executive leaders during daily meetings. The quality manager (called the Performance Improvement Manager at this healthcare system) stated the Performance/Measurement Improvement team also reviewed events entered into the Joint Patient Safety Reporting system weekly to identify trends.[24] The Patient Safety Manager described reviewing Joint Commission information to determine whether an adverse event met criteria for a sentinel event and provided examples such as falls with major injuries, retained surgical objects, and invasive procedures. According to the Patient Safety Manager, when sentinel events resulted in major harm or death, the Performance Improvement Manager and staff met with executive leaders to determine whether they warranted an institutional disclosure.

The OIG requested sentinel events and institutional disclosures that occurred from October 1, 2021, through September 30, 2022, and reviewed events reported by healthcare system staff. The OIG also discussed the results of the previous comprehensive healthcare inspection, initiated in June 2021, with the Performance Improvement Manager. The manager acknowledged that the two recommendations related to adverse events remained open but explained staff had implemented the resulting actions plans, including a sentinel event tracker.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[23] "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[24] VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance.*

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[25] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[27]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[28] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[29]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[30] 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."[31] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[32]

The OIG team interviewed key managers and staff and reviewed relevant documents. The team also reviewed 20 Level 3 peer reviews and seven unexpected deaths that occurred within 24 hours of inpatient admission during FY 2022.[33]

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

[26] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (VHA rescinded and replaced this directive with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022. Both directives have same or similar language regarding accreditation requirements for The Joint Commission.)

[27] VHA Directive 1100.16.

[28] VHA Handbook 1050.01.

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

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

[31] VHA Directive 1190.

[32] VHA Directive 1190.

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

Quality, Safety, and Value Findings and Recommendations

VHA requires peer reviewers to identify at least one aspect of care when they initially assign a Level 2 or 3 to a peer review.[34] The OIG evaluated 20 peer reviews and found 3 did not have at least one aspect of care identified. Failure to identify aspects of care could prevent an accurate and thorough review and potentially hinder quality improvement efforts. The Acting Executive Chief of Staff stated the noncompliance was due to the peer reviewers' lack of attention to detail.

Recommendation 1

1. The Executive Chief of Staff ensures peer reviewers identify at least one aspect of care when assigning a Level 2 or 3 to a peer review.

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response: The Performance Improvement Manager established a process to review all completed peer reviews to ensure that at least one aspect of care was assigned for all Level 2 or 3 peer reviews. A weekly meeting is scheduled with the Patient Safety Manager, Risk Manager and Quality Management Department Program Assistant. The purpose of the meeting is to review all completed peer reviews to ensure that any level 2 or 3 peer review has at least one aspect of care documented. Any level 2 or 3 peer review that does not have at least one documented aspect of care is sent to the Service Chief to follow up with the peer reviewer, amend the peer review and then return the peer review back to the Quality Management Department by uploading the completed peer review to the Peer Review SharePoint. The weekly meeting was established in January of 2023.

All level 2 and 3 peer reviews are reviewed at the monthly Peer Review Committee meeting. The Peer Review Committee meeting is chaired by the Executive Chief of Staff. The Peer Review Committee reports monthly to the Clinical Executive Board that is also chaired by the Chief of Staff. Compliance will be achieved when 90 percent of all level 2 and 3 peer reviews have at least one aspect of care documented for 6 consecutive months.

VHA requires the peer review committee to recommend "non-punitive, non-disciplinary actions to improve the quality of health care delivered" and for the reviewed provider's supervisor to

[34] A peer review is assigned a Level 2 when "most experienced and competent clinicians might have managed the case differently but it remains within the standard of care." Aspects of care are clinical actions used to determine the level of care provided. VHA has identified nine aspects of care: "(1) Choice and/or timeliness in ordering of diagnostic tests. (2) Addressing abnormal results of diagnostic tests. (3) Timeliness of treatment initiation and/or appropriate treatment choice. (4) Performance of a procedure or treatment. (5) Timeliness and/or appropriateness of diagnosis. (6) Recognition and communication of critical clues to patient's clinical condition. (7) Timely initiation of appropriate actions during periods of clinical deterioration. (8) Health record documentation. (9) Supervision of health profession trainees." VHA Directive 1190.

communicate the recommendations to the provider for those cases assigned a Level 2 or 3 and "ensure that appropriate action is implemented."[35] The OIG found the Peer Review Committee did not consistently recommend improvement actions for final Level 3 reviews.

Additionally, for some of the final Level 3 peer reviews with recommended actions, the OIG found the provider's supervisor did not communicate the actions or ensure they were implemented. When providers are unaware of recommended corrective actions or do not implement them, their patient care practices are unlikely to improve. The Acting Executive Chief of Staff reported believing that group communication with the providers met the requirement, provided a more holistic approach, and aided with trainee education. The OIG subsequently received evidence that group communication occurred via meetings and emails.

Recommendation 2

2. The Executive Chief of Staff ensures the Peer Review Committee recommends improvement actions to reviewed providers.

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: The Peer Review Committee Chairperson completes a peer review committee form on every case reviewed at the Peer Review Committee. The form was modified to include documentation of the Peer Review Committee's recommended improvement actions to reviewed providers for level 3 peer reviews. The revised form will be used at the Peer Review Committee effective for the July 2023 meeting. The recommended improvement actions will also be documented in the Peer Review Committee minutes by the Risk Manager. The Peer Review Committee meets monthly and is chaired by the Executive Chief of Staff. The Peer Review Committee reports monthly to the Clinical Executive Board that is also chaired by the Chief of Staff. Compliance will be achieved when 90 percent of all level 3 peer reviews have Peer Review Committee recommended improvement actions for reviewed providers documented on the Peer Review Committee peer review form and minutes for 6 consecutive months.

Recommendation 3

3. The Executive Chief of Staff ensures supervisors communicate the Peer Review Committee's recommendations to providers and ensure they implement improvement actions for all Level 2 and 3 peer reviews.

[35] VHA Directive 1190.

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response: The Risk Manager developed a tracking tool to ensure that all level 2 and 3 peer reviews that require Service Chief follow up are tracked until the Service Chief follow up is received. All peer reviews pending Service Chief follow up are discussed at the Peer Review Committee meeting. All Service Chief follow up received is reviewed at the Peer Review Committee as well. The Peer Review Committee meets monthly and is chaired by the Executive Chief of Staff. The Peer Review Committee reports monthly to the Clinical Executive Board that is also chaired by the Chief of Staff. Compliance will be achieved when 90 percent of all level 2 and 3 peer reviews have documented Service Chief follow up for 6 consecutive months.

The OIG noted an opportunity for staff to improve the healthcare system's process for assigning identification numbers to peer review cases. The Risk Manager who was responsible for peer review used the date of the safety event instead of a unique identification number for each peer review case, which could have created confusion for staff when tracking the cases to completion. The OIG did not make a recommendation but shared these concerns with leaders about the process.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[36] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[37]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[38] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[39]

VHA defines the Focused Professional Practice Evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[40] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[41] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[42]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[43] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the Chief of Staff. VHA also requires facilities to have credentialing and

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

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Handbook 1100.19.

[42] VHA Handbook 1100.19.

[43] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[44]

The OIG interviewed key managers and selected and reviewed the privileging folders of 29 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires clinical privileges to be facility and practitioner-specific, and service chiefs to establish additional criteria that are service-specific.[45] Leaders use these criteria for ongoing monitoring of LIPs' clinical practices.[46] The OIG found that service chiefs did not consistently evaluate LIPs with service-specific criteria. When service chiefs do not evaluate LIPs on relevant criteria, they may overlook specific practice deficiencies that could pose patient safety risks. The Acting Executive Chief of Staff and the Chief of Surgery reported documentation was incomplete due to the evaluators' lack of attention to detail.

Recommendation 4

4. The Executive Chief of Staff ensures service chiefs use service-specific criteria in the professional practice evaluations of licensed independent practitioners.

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

[45] For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

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

Healthcare system concurred.

Target date for completion: June 30, 2024

Healthcare system response: The Credentialing supervisor of the Medical Staff office will complete a review of the ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) currently in use to determine the number of Services that have implemented the VHA approved criteria, the number of Services that have not implemented the VHA approved criteria, the number of Services for which VHA approved criteria are not available. This status report will be completed in 30 days and reported to the July Professional Standards and Credentialing Board (PSCB). Those Services without VHA approved criteria will be given 3 months to develop criteria that will be reviewed and approved at PSCB, target date October 2023. The current schedule tracking tool used by the Medical Staff office and PSCB for the review of the OPPE/FPPE will be used to track criteria revisions. As each Service cycles through the reporting schedule, the scheduled report date will be their 6-month window to begin using the revised appropriate or VHA criteria.

The PSCB meets monthly and is chaired by the Executive Chief of Staff. The PSCB reports monthly to the Clinical Executive Board (CEB). The CEB is chaired by the Chief of Staff. The CEB reports to the Executive Council monthly. The Executive Council is chaired by the Director. Compliance will be achieved when 90% of Services that report to PSCB have successfully implemented the revised approved or VHA criteria for 6 consecutive months.

VHA requires the FPPE process to "be defined in advance, using objective criteria accepted by the practitioner."[47] The OIG found service chiefs did not have a consistent process to ensure LIPs accepted the FPPE criteria in advance. When practitioners are not aware of the criteria used to evaluate their performance, they may not understand FPPE expectations during this initial period. The Acting Executive Chief of Staff reported leaders partnered newly hired LIPs with proctors and expected them to review the evaluation criteria.[48] The OIG did not make a recommendation, but without VHA requiring documentation that practitioners were informed of the criteria used to evaluate their performance, facility leaders cannot monitor compliance.

[47] VHA Handbook 1100.19.

[48] VHA defines proctoring as "the activity by which a practitioner is assigned to observe the practice of another practitioner performing specified activities and to provide required reports on those observations." VHA Handbook 1100.19.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct inspections and track issues until they are resolved. The goal of VHA's environment of care (EOC) program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[49] The EOC program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[50]

The purpose of this inspection was to determine whether VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[51]

During the OIG's review of the EOC, the inspection team examined relevant documents, interviewed managers and staff, and physically inspected 10 patient care areas:

- Brooklyn VA Medical Center
  - Emergency Department
  - Medical intensive care unit (11 East)
  - Medical/surgical inpatient unit (11 West)
  - Primary/surgical care clinic (Pods A and B)
- Margaret Cochran Corbin VA Campus (Manhattan)
  - Emergency Department
  - Medical intensive care unit (11 West)
  - Medical/surgical inpatient unit (10 North)
  - Mental health inpatient unit (17 North)
  - Primary care clinic (9 North)

[49] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.

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

[51] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013; VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

- St. Albans VA Medical Center (Queens)
  - Community living center (Papillon Di Vie)

Environment of Care Findings and Recommendations

VHA requires facility leaders to have a comprehensive EOC program, which includes staff conducting environmental inspections at "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is delivered," and documenting completion of each inspection.[52] Additionally, VHA requires the comprehensive EOC coordinator to arrange physical inspections and maintain the records.[53] The OIG reviewed the FY 2022 environmental inspection reports and found that staff did not inspect some clinical areas at least twice, which could have prevented them from proactively identifying unsafe conditions.[54] The Assistant Chief of Engineering/Brooklyn reported believing that staff did not inspect some locations twice in FY 2022 because they went by the calendar year instead of the fiscal year.

Recommendation 5

5. The Deputy Medical Center Director ensures the Comprehensive Environment of Care Coordinator or designee schedules and ensures staff complete and document environment of care inspections at the required frequency.

[52] VHA Directive 1608.

[53] VHA Directive 1608.

[54] Staff did not inspect several areas at the Brooklyn VA Medical Center and the Staten Island Community-Based Outpatient Clinic twice in FY 2022.

Healthcare System concurred.

Target date for completion: December 31, 2023

Healthcare System response: Environment of Care (EOC) Coordinators (one for each campus of VA New York Harbor Healthcare System) were assigned on 1/15/2023. The EOC Coordinators adjusted the inspection schedule in performance logic to align with the frequencies required by VHA Directive 1608. The inspection schedule was updated on 1/15/2023. Since 1/15/2023 non patient care areas are scheduled for inspection at least once per fiscal year. Patient care areas are inspected twice per fiscal year. Inspection documentation and attendance are documented in performance logic at the completion of each inspection. Monthly performance logic reports are generated by the EOC Coordinators and reported monthly to the Environment of Care Committee. The Environment of Care Committee is chaired by the designated Associate Director and reports quarterly to the Executive Council. The Executive Council is chaired by the Director. In addition, the Chief, Engineering Service, or designee will perform random audits of 10% of inspection records quarterly to ensure compliance with the action plan. Compliance will be achieved when 90% of all EOC findings are completed within the required 14 business days compared to the total number of inspections scheduled for 6 consecutive months.

VHA requires the comprehensive EOC coordinator to monitor the deficiencies staff identified during inspections and the completion of any corrective action plans.[55] The OIG reviewed the system's FY 2022 inspection deficiency lists and noted that staff had not corrected deficiencies or developed action plans to resolve most of the issues. Unresolved deficiencies could pose threats to the physical safety and well-being of patients, staff, and visitors. The Chief of Engineering was not aware deficiencies could be monitored in the inspection tracking system.

Recommendation 6

6. The Deputy Medical Center Director ensures the Comprehensive Environment of Care Coordinator or designee monitors environment of care inspection deficiencies until resolution.

[55] VHA Directive 1608.

Healthcare System concurred.

Target date for completion: December 31, 2023

Healthcare System response: Engineering Service assigned Engineering staff to serve as the Environment of Care (EOC) Coordinators effective 1/15/2023. The EOC Coordinators are responsible for monitoring the environment of care inspection deficiencies until resolution through performance logic. The EOC Coordinators will be invited to the Engineering Maintenance and Repair weekly meeting to ensure all deficiencies are completed within the required 14 business days. In the event of findings requiring repairs exceeding the 14-day completion timeframe, an action plan will be developed and documented in Performance Logic. Monthly performance logic reports and action plans are generated by the EOC Coordinators and reported monthly to the Environment of Care (EOC) Committee. Compliance will be achieved when 90% of monthly performance logic reports and action plans generated by the EOC Coordinators are reported to the EOC Committee for 6 consecutive months. The Environment of Care Committee is chaired by the designated Associate Director and reports quarterly to the Executive Council. The Executive Council is chaired by the Director.

VHA requires staff to test over-the-door alarms per the manufacturer's recommendations for all doors to sleeping rooms on inpatient mental health units.[56] The manufacturer's guidelines recommend that staff test the alarms weekly and an outside maintenance provider test them annually. The OIG found, and the Patient Safety Manager confirmed, that neither staff nor an outside maintenance provider tested the over-the-door alarms in the mental health inpatient unit in FY 2022. If over-the-door alarms are not tested per manufacturers' recommendations, they may fail to alert staff when patients are in immediate danger. The Patient Care Team Coordinator on the inpatient mental health unit reported being unsure if staff tested any alarms. The Patient Safety Manager added believing that because nurses were notified through the alarm system's alerts, no additional testing was needed. The OIG obtained the testing recommendations from the manufacturer and provided them to the Patient Safety Manager.

Recommendation 7

7. The Director ensures staff follow the manufacturer's recommendations for testing over-the-door alarms on inpatient mental health unit sleeping room doors.

[56] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; "Mental Health Environment of Care Checklist (MHEOCC)," National Center for Patient Safety.

Healthcare system concurred.

Target date for completion: November 30, 2023

Healthcare system response: The Mental Health Patient Care Manager established a procedure to weekly test over the door alarms in all inpatient mental health unit sleeping room doors. Weekly "walk and press tests" are conducted and documented following [the] manufacturer's recommendations to ensure all door alarms are functional. Any issues found with the functionality of the door alarms are reported to Engineering Services for corrective action by submitting a work order. Any room with a non-functioning alarm is not occupied by a patient until the alarm is repaired and functional. The weekly checks of the over the door alarms were implemented [on] May 15, 2023.

All weekly tests are reviewed monthly by the Mental Health Patient Care Manager and discussed at the Mental Health Council. The Mental Health Council, chaired by the Associate Chief of Mental Health, meets monthly and reports quarterly to the Clinical Executive Committee that is chaired by the Chief of Staff. Compliance will be achieved when 90 percent of all weekly scheduled tests are completed and documented for 6 consecutive months. The testing will continue to be performed weekly as to follow VHA and manufacturer's guidelines.

The Occupational Safety and Health Administration requires staff to post hazard warning signs where potentially infectious materials are located.[57] The OIG identified areas that lacked the appropriate signage.[58] A lack of hazard signage could place patients, staff, and visitors at risk for exposure to infectious materials. The Associate Director/Finance was not aware of the requirement.

Recommendation 8

8. The Deputy Medical Center Director ensures staff post hazard warning signs in all areas where potentially infectious materials are located.

[57] Occupational Safety and Health Administration Standards, 29 C.F.R. § 1910.145(e)(4). "Biological hazard signs. The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents."

[58] The OIG observed missing hazard warning signs at the Brooklyn VA Medical Center Emergency Department, the Margaret Cochran Corbin VA Campus (Manhattan) medical/surgical inpatient unit (10 North), and the St. Albans VA Medical Center (Queens) community living center (Papillon Di Vie).

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: Engineering staff placed the appropriate hazard warning signs on areas identified during the OIG-CHIP visit; placement was completed by June 30, 2023. Room signage will be reviewed/inspected during the weekly environment of care rounds. Any room in need of signage will be noted as a deficiency. The environmental protection specialist or industrial hygienist will be alerted of any signage deficiencies to correct the deficiency. In addition, a hazardous chemical inventory is completed bi-annually to confirm locations and correct signage if needed. Signage corrections noted during EOC rounds will be captured in the monthly performance logic reports. The Environment of Care (EOC) Coordinator is responsible for generating monthly performance logic reports and ensuring timely follow-up of all EOC deficiencies. Monthly performance logic reports of EOC rounds are reported monthly to the Environment of Care Committee. The Environment of Care Committee is chaired by the designated Associate Director and reports quarterly to the Executive Council. The Executive Council is chaired by the Director. Compliance will be achieved when 90% room signage identified as needing update/corrections is completed and documented in performance logic are reported to the EOC Committee for 6 consecutive months.

VHA requires all medical facilities to "provide a safe, clean, and high quality environment of care for Veterans, their families, visitors, and employees."[59] In the 10 clinical areas inspected, the OIG found one or more of the following: wall and furniture damage; missing, damaged, or stained ceiling tiles; and peeling wallpaper with black deposits along seam lines. The OIG also observed dusty patient care areas with corrugated boxes; and dirty ventilation grills, equipment, floors, and dispensing tubes on ice and water machines.[60] Dirty and damaged patient care areas increase the risk of contamination and pathogen exposure. The Associate Director/Finance attributed the deficiencies to the 50 percent vacancy rate in Environmental Management Services.

Recommendation 9

9. The Deputy Medical Center Director ensures staff keep patient care areas safe and clean.

[59] VHA Directive 1608.

[60] Corrugated boxes are an infection control concern because they can house pests and droppings, which can later become an infestation. "What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers," The Joint Commission, accessed February 27, 2023, https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/infection-prevention-and-control-ic/000002145/.

Healthcare System concurred.

Target date for completion: December 31, 2023

Healthcare System response: Environmental Management Service (EMS) has increased the frequency of supervisors' inspections of patient rooms/patient care areas to ensure that patient care areas are adequately and consistently cleaned throughout the day and during off hours. Supervisors were required to complete 5 inspections per day. Effective 6/15/2023, they are still required to inspect five (5) areas per day and three (3) of these areas must be a patient room/patient care area. Effective 6/20/2023, the designated Associate Director began doing rounds/inspections three times a week and following up with supervisory staff regarding any findings. The Associate Director will notate findings on a spreadsheet which will identify the areas inspected and any deficiencies. Deficiencies will be shared with the Chief of EMS for action/attention. During these rounds, furniture is also being inspected for damages. Any damaged furniture found will be notated on the spreadsheet and replacement requested. Ice machines are being inspected weekly and a weekly task check list has been implemented effective 6/10/2023. The supervisor's checklists are reviewed by the Chief of EMS and the Associate Director weekly. The Associate Director will compare the supervisor's checklist with findings for all areas. These proactive measures will enhance the safety and cleanliness of these areas. Compliance will be monitored until 90 percent compliance with the increased inspection of patient rooms/patient care areas frequency is maintained for six consecutive months. These findings will be reported monthly to the Environment of Care Committee by the Chief of EMS.

The OIG also identified other environmental vulnerabilities. The OIG observed expired commercial supplies in two locations.[61] In the community living center, the OIG found unlabeled bottles of water which staff reported had thickener added for patients with difficulty swallowing. The Margaret Cochran Corbin VA Campus's Emergency Department lacked adequate signage, which could make it difficult for patients to locate. The OIG team discussed these additional items with leaders but did not make a recommendation.

[61] The OIG observed expired commercial supplies at the Brooklyn VA Medical Center Emergency Department and the St. Albans VA Medical Center community living center (Papillon Di Vie).

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[62] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[63] The suicide rate for veterans was higher than for nonveteran adults during 2020.[64] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[65]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[66] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[67]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[68]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and managers and reviewed relevant documents and the electronic

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

[63] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023, https://www.cdc.gov/suicide/facts/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fsuicide%2Ffastfact.html.

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

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

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

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

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

health records of 41 patients who had a positive suicide screen in FY 2022 and received primary care services.

Mental Health Findings and Recommendations

VHA requires the suicide prevention coordinator to "facilitate monthly reporting to local mental health leadership and quality management" staff on suicide-related events.[69] The OIG found the healthcare system lacked a process for reporting at the local level; although staff had an established email group for communication, they sent notification of all events directly to the VISN. Without suicide-related event reporting at the local level, the system's mental health team could miss opportunities to monitor at-risk patients and provide timely intervention. The Suicide Prevention Coordinator, Psychology Section Chief, and Associate Chief of Staff for Mental Health reported believing the electronic notifications to VISN and VA Central Office met the requirement.

Recommendation 10

10. The Executive Chief of Staff ensures suicide prevention coordinators report suicide-related events to mental health leaders and quality management staff at least monthly.

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: A report of all suicide-related behaviors entered in the electronic record via the Suicide Behavior and Overdose report (SBOR) and the Comprehensive Suicide Risk Evaluation (CSRE) is being generated monthly by the Performance Improvement Manager and forwarded in email form to local mental health leadership and Quality Management staff for local level awareness. The results of this monthly report will be noted quarterly in the Mental Health Council minutes. The Mental Health Council is chaired by the Associate Chief of Staff for Mental Health. The Mental Health Council reports quarterly to the Clinical Executive Board, chaired by the Chief of Staff. Compliance standard will be 90% of SBORs and CSRE will be reported to Mental Health and Quality Management leadership for 6 consecutive months (i.e., the number of SBORs and CSREs each month will match the respective number reported to leadership).

In ambulatory care settings, VHA requires designated staff to complete a suicide risk evaluation following a positive screen. Staff should complete the evaluation on the same calendar day unless it is "not logistically feasible or clinically appropriate," such as situations where urgent or

[69] VHA Directive 1160.07.

emergent care is needed. In these situations, once staff confirms patient safety, they should complete the evaluation within 24 hours of the positive screen.[70] The OIG determined staff did not complete the Comprehensive Suicide Risk Evaluation for 44 percent of patients who had a positive screen, based on the electronic health records reviewed.[71] The OIG also determined that, of the evaluations reviewed, staff did not complete 39 percent of them on the same calendar day.[72] Failure to complete the Comprehensive Suicide Risk Evaluation, or to complete it on the same day, poses a potential patient safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result.

The Associate Chief of Staff for Mental Health and the Psychology Section Chair acknowledged that primary care staff needed additional education on accurate and timely completion of the suicide risk screen and evaluation. These leaders also reported believing staff could complete the Comprehensive Suicide Risk Evaluation within 24 hours rather than the same calendar day. However, the OIG observed that for the patients who were not evaluated on the same day as the positive screen, staff also did not evaluate them within 24 hours.

Recommendation 11

11. The Executive Chief of Staff ensures designated staff complete a Comprehensive Suicide Risk Evaluation on the same calendar day as a positive suicide risk screen, when logistically feasible and clinically appropriate, for all ambulatory care patients.

[70] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)."

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

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

Healthcare system concurred.

Target date for completion: January 1, 2024

Healthcare system response: To assure that the Comprehensive Suicide Risk Evaluation (CSRE) is performed the same day, the suicide prevention team (SPC) monitors a report daily to identify all Columbia Suicide Severity Rating Scale (CSSRS) screenings that were completed that day. The report allows the SPC team to identify all positive CSSRS that were not accompanied with a CSRE. In the event of a missing CSRE, the SPC team reaches out to the provider to inform them that a CSRE is required. If the provider is unable to complete the CSRE, the SPC team will attempt to reach out to the Veteran to complete the CSRE. Additional training and in-services have been provided to targeted areas that would benefit from additional CSSRS training. The results of this report monitoring by the SPC team will be noted quarterly in the Mental Health Council minutes. The Mental Health Council is chaired by the Associate Chief of Staff for Mental Health. The Mental Health Council reports quarterly to the Clinical Executive Board, chaired by the Chief of Staff. Compliance standard will be: 90% of CSREs will be completed [the] same calendar day for 6 consecutive months.

VHA requires clinical staff to notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.[73] The OIG found that staff did not notify the suicide prevention team for one of six patients who reported suicidal behaviors. When staff fail to notify the suicide prevention team of patients' suicidal behaviors, they may inadvertently delay further evaluation and mental health intervention. The Suicide Prevention Coordinator attributed this oversight to clinical staff using an incorrect electronic health record note to document the evaluation, so the system did not send an automatic notification to the suicide prevention team. The Suicide Prevention Coordinator reported staff recently removed the incorrect template from the electronic health record to eliminate this confusion.

Recommendation 12

12. The Executive Chief of Staff ensures clinical staff notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.

[73] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer Memorandum, "Suicide Behavior and Overdose Reporting."

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: Training in suicide prevention procedures is provided to all staff in new employee orientation. In addition, the suicide prevention coordinators (SPCs) provided frequent trainings and in-services on suicide risk assessment to both Mental Health (MH) and non-MH providers. Suicide behaviors reported in the Comprehensive Suicide Risk Evaluation (CSRE) and/or Suicide Behavior and Overdose report (SBOR) in the electronic medical record automatically alert SPCs if rated at "high" or "moderate" risk at either acute or chronic levels. SPCs will work with the clinical informatics team to create a signature required in the electronic medical record for acknowledgment of all CSRE/SBORs received. Compliance standard will be that 90% of CSRE/SBORs documented in the electronic medical record will be reviewed and acknowledged by SPCs. The information to support this metric will be provided by the clinical informatics team to the SPCs and the Associate Chief of Staff for Mental Health.

The report will be noted quarterly in the Mental Health Council minutes. The Mental Health Council is chaired by the Associate Chief of Staff for Mental Health. The Mental Health Council reports quarterly to the Clinical Executive Board, chaired by the Chief of Staff. Compliance standard will be: 90% of CSREs/SBORs documented in the electronic medical record will be reviewed and acknowledged by the SPCs for 6 consecutive months.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided 12 recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this healthcare system. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines 12 OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Director, Deputy Medical Center Director, and Executive Chief of Staff. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• Peer reviewers identify at least one aspect of care when assigning a Level 2 or 3 to a peer review. • Peer Review Committee recommends improvement actions to reviewed providers. • Supervisors communicate the Peer Review Committee's recommendations to providers and ensure they implement improvement actions for all Level 2 and 3 peer reviews.
Medical Staff Privileging	• Service chiefs use service-specific criteria in the professional practice evaluations of licensed independent practitioners.
Environment of Care	• The Comprehensive Environment of Care Coordinator or designee schedules and ensures staff complete and document environment of care inspections at the required frequency. • The Comprehensive Environment of Care Coordinator or designee monitors environment of care inspection deficiencies until resolution. • Staff follow the manufacturer's recommendations for testing over-the-door alarms on inpatient mental health unit sleeping room doors. • Staff post hazard warning signs in all areas where potentially infectious materials are located. • Staff keep patient care areas safe and clean.

Review Areas	Recommendations for Improvement
Mental Health: Suicide Prevention Initiatives	• Suicide prevention coordinators report suicide-related events to mental health leaders and quality management staff at least monthly. • Designated staff complete a Comprehensive Suicide Risk Evaluation on the same calendar day as a positive suicide risk screen, when logistically feasible and clinically appropriate, for all ambulatory care patients. • Clinical staff notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.

Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 2.[1]

Table B.1. Profile for VA NY Harbor Healthcare System (630)
(October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$747,223,777	$812,434,384	$806,956,087
Number of:			
• Unique patients	45,119	48,891	47,420
• Outpatient visits	631,399	698,184	633,790
• Unique employees§	2,851	2,802	2,588
Type and number of operating beds:			
• Community living center	179	179	179
• Domiciliary	66	66	26
• Medicine	77	77	77
• Mental health	42	42	42
• Rehabilitation medicine	8	8	–
• Surgery	24	24	24
Average daily census:			
• Community living center	113	105	116
• Domiciliary	30	9	11
• Medicine	58	58	61
• Mental health	22	18	16
• Rehabilitation medicine	1	0	–

[1] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high volume, high risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," January 28, 2021. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census, cont.:			
• Surgery	12	12	12

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

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

**October 1, 2019, through September 30, 2020.*
†October 1, 2020, through September 30, 2021.

‡*October 1, 2021, through September 30, 2022.*

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 23, 2023

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

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

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

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

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

(Original signed by:)

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

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: June 20, 2023

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

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

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

I have reviewed the draft report-Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York. I concur with the findings and recommendations.

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

(Original signed by:)

Timothy H. Graham
Executive Director

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