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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York

CHIP Report | **23-00011-73** | **February 13, 2024**

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Figure 1. *Samuel S. Stratton VA Medical Center in Albany, New York. Source: https://www.va.gov/albany-health-care/locations/ (accessed February 2, 2023).*

Abbreviations

ADPNS	Associate Director for Patient/Nursing Services/Chief Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
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 Samuel S. Stratton 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 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 Samuel S. Stratton VA Medical Center during the week of February 13, 2023. 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 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 10 recommendations to the Executive Medical Center Director and Chief of Staff in the following areas of review: 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 medical center. The intent is for leaders to use recommendations as a road map to help 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 25.

VA Comments

The Veterans Integrated Service Network Director and Executive Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 29–30, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 4 and 6 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Samuel S. Stratton VA Medical Center 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 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 addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Samuel S. Stratton VA Medical Center includes multiple outpatient clinics in New York. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review during the week of February 13, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of the inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] 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 Executive Medical Center 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 OIG's last comprehensive healthcare inspection of the Samuel S. Stratton VA Medical Center occurred in July 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in June 2021.

[6] 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.[7] 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."[8] 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.[9]

To assess this medical center'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 medical center 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 medical center had a leadership team consisting of the Executive Medical Center Director (Director), Associate Director, Chief of Staff, and Associate Director for Patient/Nursing Services/Chief Nurse Executive (ADPNS). The Chief of Staff and ADPNS 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 two years and seven months. The Director explained that the Deputy Chief of Staff reported to the Chief of Staff, and the Assistant Director, whose position was new to the organization, reported to the Associate Director.

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

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

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

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPNS, Associate Director, Deputy Chief of Staff, and Assistant Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $349,020,257 increased by approximately 4 percent compared to the previous year's budget of $334,652,130.[10] However, the OIG also noted the medical center's total number of patients and employees, outpatient visits, and average inpatient daily census decreased in FY 2022. The Chief of Staff attributed the average daily census decrease to fewer hospitalizations after the COVID-19 pandemic. The ADPNS said nursing staff had decreased due to turnover, national shortages, and salaries being uncompetitive with local community hospitals, which adversely affected recruitment. The Director reported spending funds on staffing, supplies, and pharmacy medications. The Assistant Director stated the budget included funding for a new dialysis unit, radiology equipment, air conditioning components, and electrical upgrades.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] 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 without fear of reprisal.[12] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The medical center's scores indicated employees felt comfortable disclosing suspected violations compared to VHA employees overall. The Director attributed this to leaders visiting inpatient and outpatient areas and holding town hall meetings to enhance communication with staff. The Chief of Staff described promoting a culture where staff identified systemic issues and leaders tracked them to resolution. The Associate Director explained the importance of leader transparency and building trust with staff.

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

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

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

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
Samuel S. Stratton VA Medical Center	3.9	4.0	3.9

Source: VA All Employee Survey (accessed November 8, 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.[13] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

Inpatient scores were lower than VHA averages in FY 2020 but higher in FYs 2021 and 2022. The ADPNS discussed actions implemented to improve discharge planning, reduce nighttime noise, and promote hourly patient checks and interdisciplinary team patient visits. Primary and specialty care scores indicated patients were satisfied with the care they received. The Director said staff satisfaction contributed to above VHA-average patient satisfaction.

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

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	65.8	69.7	72.6	68.9	69.3
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	86.0	81.9	84.4	81.7	84.6
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	87.7	83.3	83.4	83.1	85.1

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 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 Medical Center 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.[14] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[15] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[14] 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/.

[15] 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, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[16]

"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)."[17] 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."[18] 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."[19] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[20]

The OIG requested sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. The Patient Safety Manager explained staff primarily reported adverse events through the Joint Patient Safety Reporting system and discussed them with executive leaders daily in morning meetings.[21] The Risk Manager explained the process for conducting institutional and large-scale disclosures and described frequently meeting with the Chief of Staff to discuss concerns. The Chief of Staff reported having a strong relationship with quality management staff and being actively involved in the institutional disclosure process.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[17] 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.

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

[19] VHA Directive 1004.08.

[20] VHA Handbook 1050.01, V*HA 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.)

[21] "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.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[22] 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.[23] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[24]

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 medical center vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[25] 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.[26]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[27] 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."[28] Peer reviews are "intended to promote confidential and non-punitive assessment of care" that consistently contribute to quality management efforts at the individual provider level.[29]

The OIG team interviewed key managers and reviewed relevant documents.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

[23] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[24] VHA Directive 1100.16.

[25] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[27] 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.

[28] VHA Directive 1190.

[29] VHA Directive 1190.

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."[30] 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."[31]

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.[32] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[33]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE process occurs when an LIP is hired at the facility and granted initial or additional privileges. 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.[34]

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.[35] 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

[30] 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.)

[31] VHA Handbook 1100.19.

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[36]

The OIG interviewed key managers and selected and reviewed the privileging folders of 26 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 service-specific criteria.[37] Leaders use these criteria for ongoing monitoring of LIPs' clinical practices.[38] The OIG found service chiefs did not consistently evaluate LIPs using 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 Chief of Staff said one of the reasons was that evaluators documented criteria on a generic form that addressed general competencies across services. The Chief of Medicine explained that other similarly trained and privileged practitioners evaluated LIPs by reviewing specialty-specific patient care documentation and reported believing this met the requirement.

Recommendation 1

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

[36] 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.

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

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

Medical center concurred.

Target date for completion: September 1, 2024

Medical center response: The Chief of Staff, in collaboration with the Health Systems Specialist for Credentialing and Privileging, will ensure that all service chiefs use service-specific criteria in the professional practice evaluations of licensed independent practitioners. Each Service Chief (Surgical Services, Medical Services, Ambulatory Medicine Services, Diagnostics and Therapeutics, Mental Health, Social Work, and Pharmacy) has submitted an updated chart review and summary sheet templates for each specialty to the Professional Standards Board for approval. All submitted forms contain service-specific criteria that aligns with the National Credentialing and Privileging Office recommendations. Each form was reviewed and approved by the Professional Standards Board. This action was completed August 3, 2023.

The Credentialing & Privileging staff has reviewed each completed Professional Practice Evaluation for use of service-specific criteria in the professional practice evaluations of licensed independent practitioners. The Credentialing & Privileging staff will conduct an audit review of two (2) professional practice evaluations of licensed independent practitioners per service per month to ensure compliance with use of the new form. A report will be submitted to the Quality, Safety, and Value Committee starting February 2024 until 90% compliance has been achieved for six consecutive months.

VHA requires practitioners with equivalent specialized training and similar privileges to complete professional practice evaluations of LIPs.[39] The OIG found that practitioners with similar training and privileges did not routinely complete LIPs' professional practice evaluations. This resulted in LIPs practicing without comprehensive evaluations, which could cause specific practice deficiencies to go unnoticed and pose patient safety risks. The Chief of Staff acknowledged one practitioner was erroneously approved for interventional cardiology privileges instead of general cardiology and stated the evaluator's privileges for general cardiology would have been similar if the error had not occurred. The Chief of Staff also reported believing that requesting a review from the practitioner's supervisor at a locally affiliated hospital met requirements, but the OIG found the supervisor was not similarly trained and privileged.

Recommendation 2

2. The Chief of Staff ensures practitioners with equivalent specialized training and similar privileges complete professional practice evaluations.

[39] Assistant Under Secretary for Health for Operations revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," May 18, 2021; VHA Directive 1100.21(1).

Medical center concurred.

Target date for completion: September 1, 2024

Medical center response: The Chief of Staff, in collaboration with the Health Systems Specialist for Credentialing and Privileging, will ensure practitioners with equivalent specialized training and similar privileges complete the professional practice evaluations. Each Service Chief (Surgical Services, Medical Services, Ambulatory Medicine Services, Diagnostics and Therapeutics, Mental Health, Social Work, and Pharmacy) began reporting each practitioner beginning March 2, 2023, who completed their Professional Practice Evaluation to the Professional Standards Board.

Each professional practice evaluation is reviewed to ensure practitioners with equivalent specialized training and similar privileges are completing the Professional Practice Evaluations. The Credentialing & Privileging staff will conduct an audit review of two (2) professional practice evaluations of licensed independent practitioners per service per month to ensure professional practice evaluations are completed by practitioners with equivalent specialized training and similar privileges. A report will be submitted to the Quality, Safety, and Value Committee starting February 2024 until 90% compliance has been achieved for six consecutive months.

VHA requires the FPPE process "to be defined in advance, using objective criteria accepted by the LIP."[40] The OIG found service chiefs did not have a consistent process to ensure LIPs accepted the FPPE criteria in advance. When LIPs are not aware of the criteria used to evaluate their performance, they may not understand FPPE expectations during this initial period. The Section Chief of Radiology acknowledged a delay in reviewing the FPPE documentation with an LIP due to being new in the position and unaware of the requirement. The Chief of Medicine could not locate the initial FPPE documentation for an LIP and attributed the deficiency partly to multiple staff covering the service chief position. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed in advance of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

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

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[41] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[42]

The purpose of this inspection was to determine whether staff at 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.[43]

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

- Community living center (Heroes Way 9B)
- Emergency Department
- Intensive care unit (2D)
- Medical/surgical inpatient unit (8B)
- Mental health inpatient unit (10B)
- Primary care clinic (Red Team 4B)

Environment of Care Findings and Recommendations

VHA requires facility leaders to have a comprehensive environment of care program, which includes staff conducting environmental inspections at "a minimum of once per fiscal year in

[41] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[42] 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.

[43] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

non-patient care areas, and twice per fiscal year in all areas where patient care is delivered."[44] Additionally, VHA requires the comprehensive environment of care coordinator to arrange physical inspections and maintain the records.[45] The OIG found staff did not inspect some clinical locations at least twice in FY 2022, which could have prevented them from proactively identifying unsafe conditions.[46] The Associate Director stated the coordinator scheduled two community-based outpatient clinic inspections for the last day in FY 2022 but did not complete them until FY 2023. The Emergency Manager acknowledged these delayed inspections were due to a scheduling oversight.

Recommendation 3

3. The Executive Medical Center Director ensures the Comprehensive Environment of Care Coordinator schedules, and staff complete and document, environment of care inspections at the required frequency.

Medical center concurred.

Target date for completion: July 1, 2024

Medical center response: The Medical Center Director will ensure the Comprehensive Environment of Care Coordinator schedules and documents environment of care inspections at the required frequency. The Comprehensive Environment of Care Coordinator previously created the Environment of Care inspection schedule with appropriate frequency of inspections for all locations based on the calendar year. The Comprehensive Environment of Care Coordinator changed the Environment of Care inspection schedule with appropriate frequency of inspections based on the fiscal year. This meets VHA Directive requirements for inspections and submission of inspection findings to occur at a minimum frequency of once per fiscal year in non-patient areas and twice per fiscal year in all areas where patient care is delivered. The Environment of Care rounding schedule was submitted to the Quality, Safety, and Value Committee on January 24, 2024, to ensure the frequency of scheduled environment of care rounds is accurate. The Comprehensive Environment of Care Coordinator will report completion of scheduled Environment of Care rounds for the fiscal year to the Quality, Safety, and Value Committee until 90% compliance is met for two consecutive quarters.

[44] VHA Directive 1608.

[45] VHA Directive 1608.

[46] Staff did not inspect the following locations twice in FY 2022: the Catskills and Kingston community-based outpatient clinics, post-anesthesia care unit, pharmacy, and Silver Team primary care clinic.

VHA requires staff to periodically test panic alarms in the mental health inpatient unit and document VA Police response times.[47] The OIG found that police tested the alarm system monthly, but staff did not document police response times. Failure of staff to monitor police response times for panic alarm activation on the mental health inpatient unit may place patients, visitors, and staff at risk in emergency situations. The Chief of Police reported police test the panic alarms monthly but were unaware of the requirement for staff to document police response times.

Recommendation 4

4. The Executive Medical Center Director ensures staff document police response times to panic alarm testing in the mental health inpatient unit.[48]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Medical Center Director will ensure that police response times to panic alarm testing in the mental health inpatient unit is tested monthly and documented. The Physical Security Specialist Police Officer tested police response times to panic alarms on the inpatient mental health unit but did not document response times. The Physical Security Specialist Police Officer created a document to track monthly panic alarm testing. Use of this document started in April 2023, and is tracked monthly by the Physical Security Specialist Police Officer to ensure response is timely 100% of the time. A report for April through November 2023 showing 100% compliance was submitted to the Quality, Safety, and Value Committee on January 24, 2024.

VHA requires all sleeping room doors in mental health inpatient units to have over-the-door alarms and staff to test the alarms per the manufacturer's recommendations.[49] The manufacturer's guidelines recommend staff test the alarms monthly. The OIG reviewed two months of alarm testing documentation and found that while staff tested alarms monthly, they did not test them on all sleeping room doors. Additionally, the OIG found one room without a

[47] VHA Directive 5019.02(1), *Harassment, Sexual Assaults and Other Defined Public Safety Incidents in VHA*, September 12, 2022, amended October 13, 2022; VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients,* May 12, 2017; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," October 18, 2022; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," April 10, 2023.

[48] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

[49] VHA Directive 1167; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," October 18, 2022; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," April 10, 2023.

door alarm.[50] The OIG also observed that the room numbers on the over-the-door alarm report did not align with room numbers in the mental health inpatient unit; for example, one room number in the report was for an equipment room outside the unit that did not have a door alarm. Additionally, some rooms had double doors, but the report did not identify whether staff tested both doors. If over-the-door alarms are not installed on all sleeping room doors and tested per manufacturer recommendations, they may fail to alert staff when patients are in immediate danger. The Emergency Manager, Chief of Facility Management Service, and Chief of Mental Health reported being unaware of the room number discrepancies on their testing log and the missing over-the-door alarm.

Recommendation 5

5. The Executive Medical Center Director ensures appropriate personnel install over-the-door alarms for sleeping room doors in the mental health inpatient unit.

Medical center concurred.

Target date for completion: October 30, 2024

Medical center response: The Director, in collaboration with the Emergency Manager, Chief of Facility Management Service, and Chief of Mental Health will ensure appropriate personnel install over-the-door alarms for sleeping room doors in the mental health inpatient unit. During the OIG inspection, inspectors questioned why an over-the-door alarm was not installed on the doors entering seclusion room B1007-C. Inpatient mental health staff, facility safety staff and the patient safety manager stated these doors are always locked when the room is unoccupied to mitigate use by another inpatient. These doors are checked in their environmental rounds and are visualized by the hallway monitor. This room is assigned a one-to-one sitter with constant observation when this room is occupied by a patient, therefore mitigating the risk for suicide. Checking the seclusion room door is included in the 10B Environment of Care Checklist. This room is not used as a sleeping room for overflow patients. Over-the-door alarms will be installed on seclusion room doors. Once over-the-door alarms are installed monitoring by the Inpatient Mental Health Unit Nurse Manager and quality management staff for over-the-door alarm testing will be completed monthly. A monthly report will be submitted to the Quality, Safety, and Value Committee once installation of over-the-door-alarms is completed and testing started until 100% compliance has been achieved for six consecutive months.

[50] The room without an over-the-door alarm was in the mental health inpatient unit (10B).

Recommendation 6

6. The Executive Medical Center Director ensures staff follow the manufacturer's recommendations for testing over-the-door alarms on sleeping room doors in the mental health inpatient unit.[51]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Director, in collaboration with the Emergency Manager, Chief of Facility Management Service and Chief of Mental Health ensures staff follow the manufacturer's recommendations for testing over-the-door alarms on sleeping room doors in the mental health inpatient unit. During the OIG inspection, facilities management staff provided a "Top Door Alarm Checklist" as evidence of routine testing of over-the-door alarms on the inpatient mental health unit. The quality specialist and OIG inspector could not find patient room B1003 listed on the checklist. When leaving the secured inpatient mental health unit, there is a supply equipment room numbered 1003. At that time, it was decided by the quality specialist and OIG inspector that this must be the room listed on the checklist for routine over-the-door alarm testing and therefore the room numbers on the list were incorrect. Additionally, checklist columns did not indicate testing of both doors. Checklist updated to include correct room numbers and testing of both doors. The use of this form for documentation started in April 2023 and monitored monthly by the Inpatient Mental Health Unit Nurse Manager and quality management staff. A report for 100% compliance with over-the-door testing for the past six consecutive months - April to October 2023, was reported to the Quality, Safety, and Value Committee on January 24, 2024.

VHA requires mental health inpatient unit staff to ensure a safe and therapeutic environment of care, supported by using the Mental Health Environment of Care Checklist during inspections.[52] The OIG observed conditions that did not align with checklist requirements despite staff documenting all standards were met.[53] Failure to address environmental safety concerns in the mental health inpatient unit could result in patient, visitor, or staff injury. The Chief of Mental Health explained staff had tried to create a more home-like environment but also acknowledged being unaware of the specific requirements in the Mental Health Environment of Care Checklist.

[51] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

[52] VHA Handbook 1160.06.

[53] The OIG observed unmonitored blind spots in hallways, unsecured ceiling tiles (self-harm risk), easily movable day room furniture and a large coffee carafe (potential weapons), coffee stirrers and plastic spoons (potential weapons), an unattended linen cart in a hallway (self-harm risk), patient access to medical equipment (self-harm risk), non-collapsible trash cans that are strong enough for patients to stand on (hanging risk), tiled walls in bathrooms (self-harm risk), a vinyl pillow (suffocation risk), a fitted sheet (hanging hazard), a non-cushioned seclusion room floor (injury risk), and an unattended maintenance cart holding hazardous chemicals (poison risk).

Recommendation 7

7. The Executive Medical Center Director ensures staff maintain a safe environment in the mental health inpatient unit.

Medical center concurred.

Target date for completion: September 1, 2024

Medical center response: The Director, in collaboration with the Chief of Staff, Associate Director for Patient Care Services, and Chief of Facilities Management ensures staff maintain a safe environment in the mental health inpatient unit. Hazardous items found during the OIG inspection that are not permitted per the Mental Health Environment of Care Checklist were removed. This included the removal of the vinyl pillows, large coffee carafe, spoons for coffee, easily movable furniture, and a non-collapsible trash can from the day room. The 10B Environment of Care Checklist was updated to include items that were removed to ensure they are not allowed on the unit and for staff to remove if found again. This checklist is completed by an assigned staff member at the beginning of each shift. The Albany standard operating procedure "Maintaining Safety and Security on Inpatient Mental Health" was updated to include requirements listed in VHA Directive 1160.06 Inpatient Mental Health Services which was released on September 27, 2023. Education of staff was completed by the inpatient MH Nurse Manager and Assistant Nurse Manager regarding the need to remove and mitigate risk for these hazardous items. Use of the 10B Environment of Care Checklist is tracked monthly by the Inpatient Mental Health Unit Nurse Manager and quality management staff. A monthly report for use of the checklist and mitigation of items found during rounding will be submitted to the Quality, Safety, and Value Committee until 90% compliance has been achieved for six consecutive months.

VHA requires staff at all medical facilities to provide a safe and clean environment.[54] The OIG observed areas with dust, stained or damaged ceiling tiles, scraped walls and handrails, peeling wallpaper, chipped paint, and a broken light cover. Additionally, the OIG found a nonfunctional negative pressure system for proper airflow, a hole in a fire barrier wall, an eyewash station not immediately accessible, unsecured and full sharps containers, a large amount of improperly stored nutrition supplements, and unsecured and expired medications and supplies that were kept outside of areas monitored by logistics and pharmacy staff.[55] The OIG also found staff had inconsistent processes for cleaning reusable equipment and posting signage for pharmaceutical

[54] VHA Directive 1608.

[55] Negative pressure rooms are "used to contain airborne contaminants within a room." "Room Pressurization," American Hospital Association, accessed August 21, 2023, https://www.ashe.org/compliance/ec_02_05_01/01/roompressurization. "Where the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use." 29 C.F.R. §1910.151(c) (1998).

waste in clinical areas. Dirty, damaged, and disorganized patient care areas increase the risk of contamination, pathogen exposure, and other safety risks.

The Assistant Chief of Nutrition and Food Services stated employees sent food supplements to the units as ordered for specific patients, and the nutrition team was unaware unit staff stored the items after patients were discharged. The Chief of Logistics said their team completed daily inspections of supply closets to check for expired items. The Chief of Logistics also reported requiring unit leaders to provide monthly verification that no items had expired. However, the OIG noted not all unit leaders consistently provided this documentation. The Chief of Pharmacy explained that due to space constraints, staff primarily used the automated dispensing cabinet for controlled substances and unit supply stock, placing other medications in locations not monitored by pharmacy staff. The prior Green Environmental Management System coordinator reported requesting updated signs for the medication rooms prior to transferring roles; however, the signs were not ready until recently.

Recommendation 8

8. The Executive Medical Center Director ensures staff keep patient care areas safe and clean.

Medical center concurred.

Target date for completion: September 1, 2024

Medical center response: The Director, in collaboration with the Associate Director, Associate Director of Patient Care Services, and Chief of Staff will ensure staff keep patient care areas safe and clean. Unit managers are responsible to submit work orders which will notify the Facility Management Service that something needs to be repaired, including stained or damaged ceiling tiles, scraped walls and handrails, peeling wallpaper, chipped paint, or a broken light cover. More urgent repairs, such as a nonfunctional negative pressure system, a hole in a fire barrier wall, an eyewash station not immediately accessible, unsecured and full sharps containers, requires notification by phone to the Facility Management Service for immediate repair and entry of a work order for tracking and documentation. For expired medications, supplies, and nutrition supplements, notification by phone to the service managers will be made on the day of finding for immediate removal of items. The Comprehensive Environment of Care Coordinator will send the environment of care percentage of deficiencies completed or action initiated within 14 days to the Quality, Safety, and Value Committee until 90% compliance is met for two consecutive quarters.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[56] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[57] The suicide rate for veterans was higher than for nonveteran adults during 2020.[58] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[59]

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.[60] 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.[61]

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.[62]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key managers and employees and reviewed relevant documents and the electronic health records of 41 patients who had a positive suicide screen in FY 2022 and received primary care services.

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

[57] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

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

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

[60] 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.)

[61] 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.)

[62] 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.)

Mental Health Findings and Recommendations

VHA requires designated staff to complete the Comprehensive Suicide Risk Evaluation when a suicide risk screen is positive.[63] In ambulatory care settings, 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 emergent care is needed. In these situations, once staff confirms patient safety, they should complete the evaluation within 24 hours of the positive screen.[64] The OIG determined staff did not complete the Comprehensive Suicide Risk Evaluation for 56 percent of patients who had a positive screen.[65] Failure of staff to complete the evaluation poses a safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The Chief of Mental Health Services and Section Chief of Primary Care explained that frequent primary care staff turnover, resulting in fewer providers caring for more patients, was a reason for missed evaluations. The Section Chief of Psychology explained providers had multiple tasks and competing priorities, which may have caused them to miss the documentation requirements.

Recommendation 9

9. The Chief of Staff ensures designated staff complete the 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.

[63] 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);" 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)."

[64] 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)."

[65] Confidence intervals were not included because the data represented every patient in the study population.

Medical center concurred.

Target date for completion: September 1, 2024

Medical center response: The Chief of Staff will ensure designated staff complete the Comprehensive Suicide Risk Evaluation on the same calendar day as a positive suicide risk screen, unless it is "not logistically feasible or clinically appropriate," such as situations where urgent or emergent care is needed for all ambulatory care patients. In April of 2023, the Suicide Prevention Team implemented a daily afternoon report of completed Columbia Suicide Severity Rating Scales (C-SSRS) to identify positive results. This is completed during regular business hours. If a positive result is found, the chart is reviewed to verify if the Comprehensive Suicide Risk Evaluation (CSRE) was completed. If the CSRE is not completed, the Suicide Prevention team ensures completion by assigning the CSRE to a suicide prevention team member. Using the daily report method, the Chief of Mental Health and the Suicide Prevention coordinator will audit medical records for a completed Comprehensive Suicide Risk Evaluation within the same calendar day for every positive suicide risk screen. A quarterly report for compliance with a completed Comprehensive Suicide Risk Evaluation (CSRE) for every positive Columbia Suicide Severity Rating Scales (C-SSRS) will be submitted to the Quality, Safety, and Value Committee until 90% compliance has been achieved for two consecutive quarters.

VHA requires the suicide prevention coordinator to conduct a minimum of "five outreach activities per month" and track and report the completed activities.[66] The OIG found the Suicide Prevention Coordinator did not conduct outreach activities in June 2022. The lack of community outreach activities may affect collaboration within the local community and could lead to missed opportunities for staff and others to identify patients in crisis. The Section Chief of Psychology was not able to provide a reason for the deficiency because the Suicide Prevention Coordinator in the role at the time had retired.

Recommendation 10

10. The Chief of Staff ensures the Suicide Prevention Coordinator conducts, tracks, and reports a minimum of five suicide prevention outreach activities monthly.

[66] VHA Directive 1160.07.

Medical center concurred.

Target date for completion: September 1, 2024

Medical center response: The Chief of Staff will ensure the Suicide Prevention Coordinator conducts, tracks, and reports a minimum of five suicide prevention outreach activities monthly. The Suicide Prevention Coordinator position was vacant with duties being covered by other mental health professionals prior to hiring the current Suicide Prevention Coordinator in the fall of 2022. The Suicide Prevention Coordinator was orienting to her new position during the time of the OIG inspection. There is evidence of completion of outreach activities from October 2022 through February 2023. The number of outreach activities range from four to five per month during this time frame. The Suicide Prevention Coordinator participated in these outreach activities as part of the orientation process and began coordinating more activities in March 2023. The Suicide Prevention Coordinator included reporting of completed outreach activities to the Quality, Safety, Value committee in September 2023. A quarterly report for compliance with completion of a minimum of five suicide prevention outreach activities per month will be submitted to the Quality, Safety, and Value Committee until 100% compliance has been achieved for two consecutive quarters.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided 10 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 medical center. 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 10 OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Executive Medical Center Director and Chief of Staff. The intent is for leaders to use 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	• None
Medical Staff Privileging	• Service chiefs use service-specific criteria in the professional practice evaluations of licensed independent practitioners. • Practitioners with equivalent specialized training and similar privileges complete professional practice evaluations.
Environment of Care	• The Comprehensive Environment of Care Coordinator schedules, and staff complete and document, environment of care inspections at the required frequency. • Staff document police response times to panic alarm testing in the mental health inpatient unit. • Appropriate personnel install over-the-door alarms for sleeping room doors in the mental health inpatient unit. • Staff follow the manufacturer's recommendations for testing over-the-door alarms on sleeping room doors in the mental health inpatient unit. • Staff maintain a safe environment in the mental health inpatient unit. • Staff keep patient care areas safe and clean.

Review Areas	Recommendations for Improvement
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the 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. • The Suicide Prevention Coordinator conducts, tracks, and reports a minimum of five suicide prevention outreach activities monthly.

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 Samuel S. Stratton VA Medical Center (528) (October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$333,116,788	$334,652,130	$349,020,257
Number of:			
• Unique patients	36,326	38, 866	37,220
• Outpatient visits	349,714	397,691	383,947
• Unique employees§	1,242	1,232	1,178
Type and number of operating beds:			
• Community living center	50	50	50
• Domiciliary	12	12	12
• Medicine	32	32	32
• Mental health	12	12	12
• Surgery	11	11	11
Average daily census:			
• Community living center	44	38	36
• Domiciliary	6	5	6
• Medicine	30	29	30
• Mental health	9	8	8

[1] VHA medical facilities are classified according to a 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." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census, cont.:			
• Surgery	5	6	5

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: January 23, 2024

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

Subj: Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York

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

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

Thank you for your review of the OIG Comprehensive Healthcare Inspection at the Samuel S. Stratton VA Medical Center in Albany, New York.

I have reviewed the medical center's plan to ensure compliance with the 10 identified recommendations and concur with them as submitted.

(Original signed by:)

JOAN E. MCINERNEY, MD, MBA, MA, FACEP
VISN 2 NETWORK DIRECTOR

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: January 23, 2024

From: Executive Medical Center Director, Samuel S. Stratton VA Medical Center (528A8)

Subj: Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York

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

I concur with the recommendations listed in the Office of Inspector General's report, Comprehensive Healthcare Inspection Program of the Samuel S. Stratton VA Medical Center Albany, New York.

(Original signed by:)

RICHARD LOUBRIEL
For and in the absence of Darlene Delancey, MS
Executive Medical Center Director

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