DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 1: VA New England Healthcare System

Bedford, Massachusetts

CHIP REPORT | REPORT #19-06866-68 | JANUARY 29, 2020

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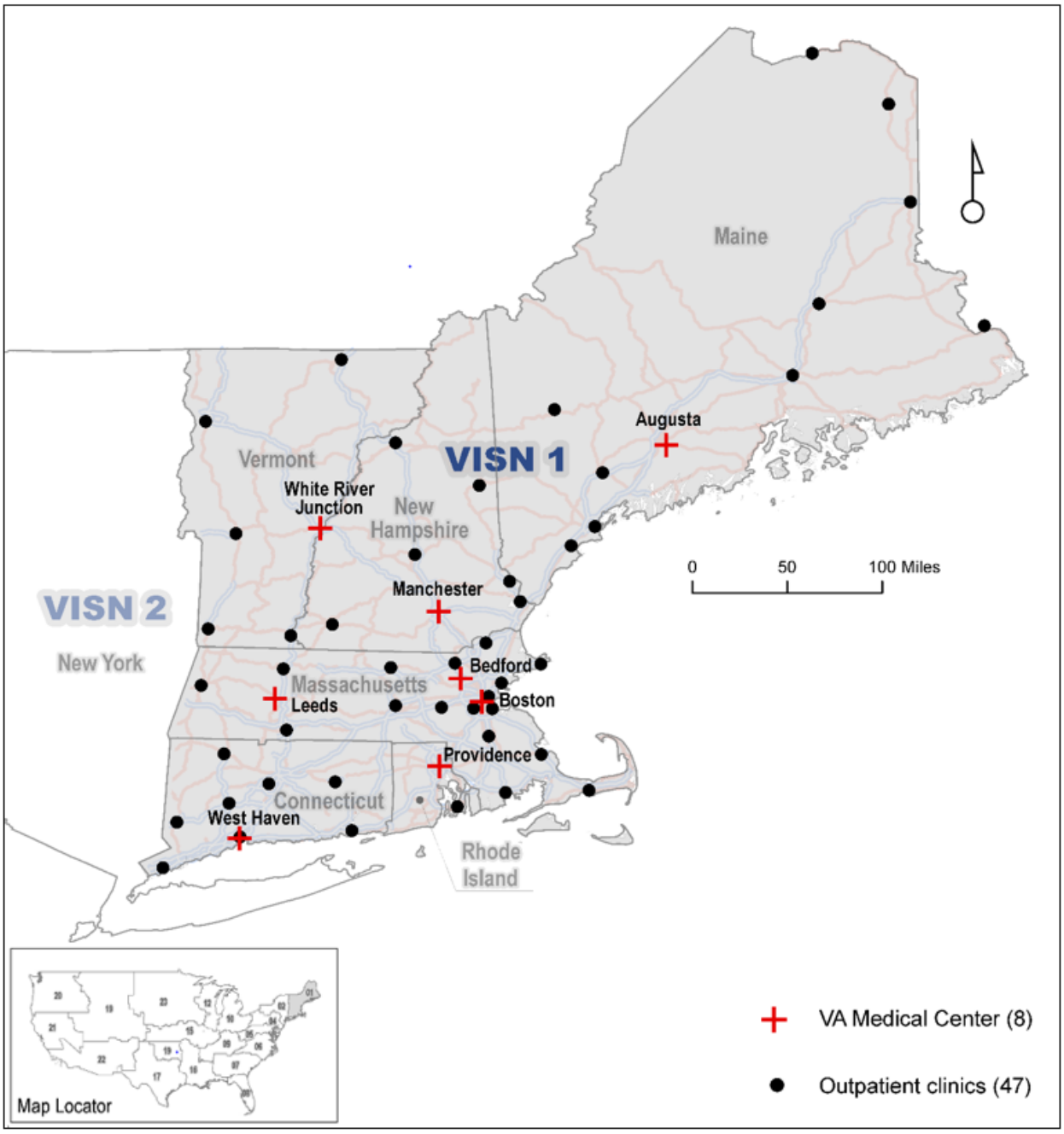

Figure 1. *Veterans Integrated Service Network 1: VA New England Healthcare System, Bedford, Massachusetts (Source: OIG)*

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
FPPE	focused professional practice evaluation
FY	fiscal year
HRO	human resource officer
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QMO	quality management officer
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of leadership performance and oversight by the Veterans Integrated Service Network (VISN) 1: VA New England Healthcare System. This inspection covers key clinical and administrative processes associated with promoting quality care.

CHIP reviews are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG selects and evaluates specific areas of focus each year.

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the inspection, the clinical areas of focus were

1. Quality, Safety, and Value;
2. Medical Staff Privileging;
3. Environment of Care; and
4. Medication Management (specifically the controlled substances inspection program).

The OIG conducted this unannounced visit during the week of June 3, 2019, while concurrent inspections of the following VISN 1 facilities were also performed:

- VA Central Western Massachusetts Healthcare System, Leeds, MA
- Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA
- Manchester VA Medical Center, Manchester, NH

The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. The findings presented in this report are a snapshot of VISN 1 and facility performance within the identified focus areas at the time of the OIG visit. The findings in this report may help the VISN identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the VISN, the leadership team consists of the network director, deputy network director, chief medical officer (CMO), quality management officer (QMO), and human resource officer. Organizational communication and accountability are managed through a committee reporting structure, with the VISN's Executive Leadership Council having oversight for groups such as the Organizational Health; Quality, Safety & Value; and Healthcare Operations Committees. The

leaders are members of the Executive Leadership Council through which VISN performance is enhanced.

All members of the leadership team are permanently assigned and have worked together as a team since December 2018.

In the review of selected employee satisfaction survey results regarding facility leaders, the OIG noted opportunities for the network director to improve employee satisfaction; the deputy network director to model servant leadership; and the network director, deputy network director, and CMO to reduce employee moral distress at work. However, it is important to note that the network director and CMO scores are not reflective of the current leaders who assumed their roles after the survey was administered. In the review of selected patient experience survey results regarding facility leaders, the OIG noted VISN scores for each of the selected survey questions are above the VHA averages, indicating that VISN 1 patients are generally more satisfied compared to all VHA patients in general. VISN leaders also supported efforts to provide accessible and inclusive care for women veterans.

The OIG's evaluation of VISN access metrics and clinician vacancies did not identify any significant organizational risks. Although interviewed leaders appeared knowledgeable about efforts taken to reduce veteran suicide as well as selected Strategic Analytics for Improvement and Learning (SAIL) and community living center (CLC) data, they should continue to take and support facility actions to improve care provided throughout VISN 1.

The OIG noted findings of deficiencies in all four clinical areas inspected and issued 12 recommendations that are attributable to the network director, deputy network director, CMO, and QMO. These are briefly described below.

Quality, Safety, and Value

The OIG found there was general compliance with requirements related to having a standing VISN committee with responsibility for key quality, safety, and value functions and the collection, analysis, and action taken in response to VISN peer review data. However, the OIG identified a concern with the completion of required inpatient stay reviews and noncompliance trends with utilization management and root cause analyses during concurrent VISN 1 facility CHIP inspections.

Medical Staff Privileging

During concurrent VISN 1 facility CHIP site visits, the OIG identified trends in noncompliance related to focused professional practice evaluations (FPPEs), ongoing professional practice evaluations, and FPPEs for cause.

Environment of Care

The OIG found evidence of an annual inventory management program assessment through a quality control review. However, the OIG identified concerns with the VISN's comprehensive environment of care policy and emergency management committee. The OIG also noted limited trends during concurrent VISN 1 facility CHIP inspections related to dirty floors and stained ceiling tiles in patient care areas that did not rise to the level of a recommendation.

Medication Management

The OIG did not identify any noncompliance trends during VISN 1 facility CHIP reviews. However, the OIG found noncompliance with the QMO's review of VISN facility quarterly trend reports.

Summary

In the review of key healthcare processes, the OIG issued 12 recommendations that are attributable to the network director, deputy network director, CMO, and QMO. The number of recommendations should not be used as a gauge for the overall quality provided within this VISN. The intent is for VISN leaders to use these recommendations as a road map to help improve operations and clinical care throughout the network of assigned facilities. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The network director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendix G, page 60, and the responses within the body of the report for the full text of the network director's 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) review is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 1: VA New England Healthcare System. This focused evaluation is accomplished by examining a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The OIG reports findings to VISN leaders so that informed decisions can be made to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[1] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[2]

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following five areas of clinical and administrative operations that support quality care:

1. Leadership and Organizational Risks
2. Quality, Safety, and Value (QSV)
3. Medical Staff Privileging
4. Environment of Care
5. Medication Management (specifically the controlled substances inspection program).[3]

[1] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (The website was accessed on January 24, 2019.)

[2] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (The website was accessed on January 24, 2019.)

[3] CHIP inspections address these processes during fiscal year 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected documents administrative and performance measure data and discussed processes and validated findings with VISN leadership and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations for December 13, 2014,[4] through June 7, 2019, the last day of the unannounced week-long site visit.

The review was performed during concurrent inspections of VISN 1's Central Western Massachusetts Healthcare System, Leeds, MA; Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA; and Manchester VA Medical Center, Manchester, NH. While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the VISN completes corrective actions. The VISN director's comments submitted in response to the report recommendations appear within each topic area.

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

[4] The range represents the time from the last Combined Assessment Program review of three VISN 1 facilities inspected simultaneously within this VISN—and in this case, the VA Central Western Massachusetts Healthcare System (Leeds, MA)—to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the ability to provide care in all the selected clinical and administrative areas of focus.[5] To assess the VISN's risks, the OIG considered the following indicators:

1. Executive leadership stability and engagement
2. Employee satisfaction
3. Patient experience
4. Access to care
5. Clinician vacancies
6. Oversight inspections
7. VHA performance data

Additionally, the OIG assessed VISN 1 efforts to reduce the rates of suicide, a leading cause of death in the United States.[6]

Executive Leadership Stability and Engagement

A VISN consists of a geographic area which encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the veterans' health care system.[7]

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[5] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

[6] The Centers for Disease Control and Prevention. *CDC Vitalsigns™,* June 2018. https://www.cdc.gov/violenceprevention/suicide/datasources.html. (The website was accessed on April 12, 2019.)

[7] Detailed explanation of VISNs provided by Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, May 22, 2018.

According to data from the VA National Center for Veterans Analysis and Statistics, VISN 1 had a veteran population greater than 890,000 within its borders at the end of fiscal year (FY) 2016. VISN 1 leaders are currently responsible for the oversight of eight medical centers and over 40 outpatient clinics.

The VISN 1 leadership team includes the network director, deputy network director, chief medical officer (CMO), quality management officer (QMO), and human resource officer (HRO). The CMO is responsible for overseeing facility-level patient care programs. Figure 3 illustrates the VISN's reported organizational structure.

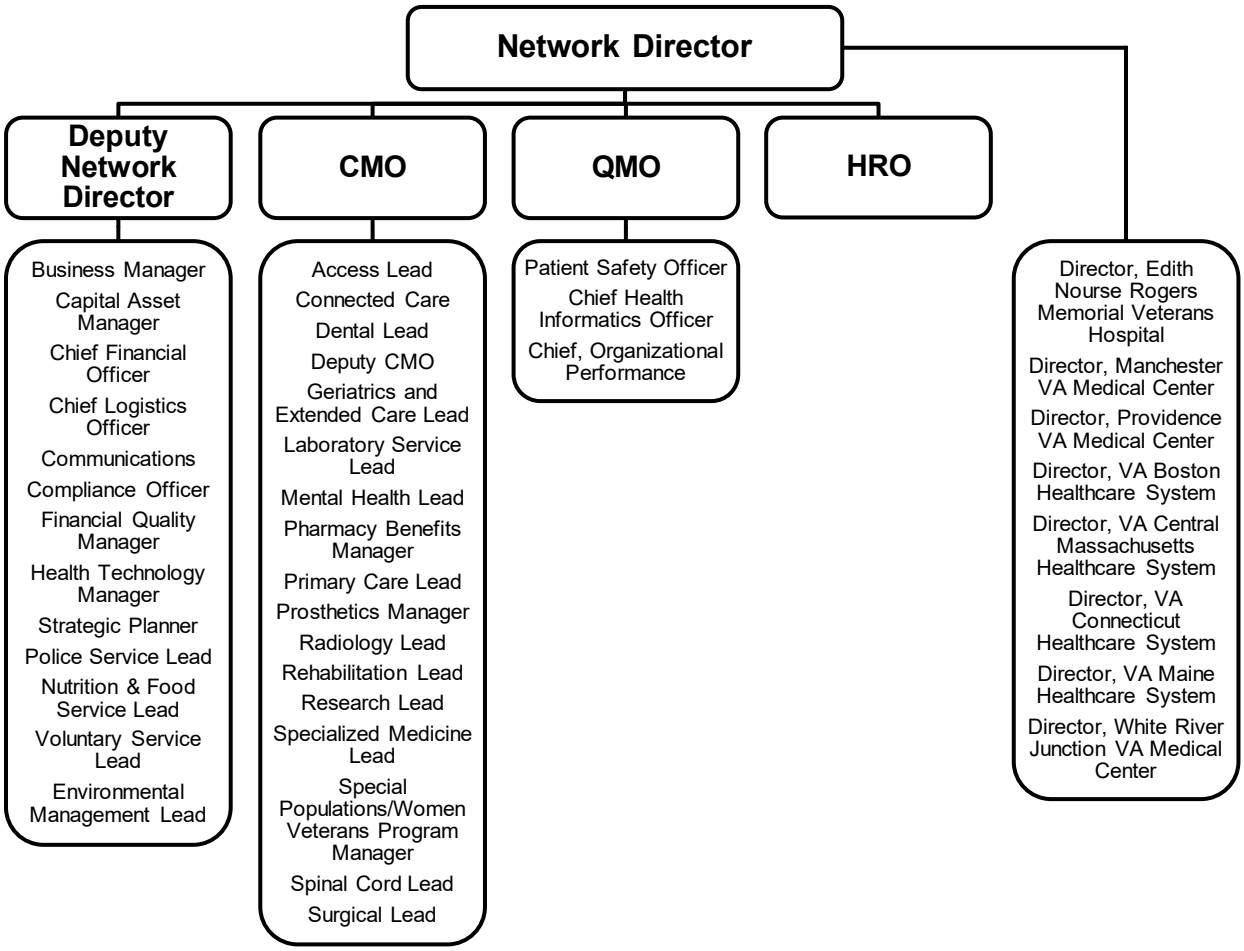

Figure 3. *VISN 1 Organizational Chart*[8]
Source: VA New England Healthcare System (received June 3, 2019)

[8] For this VISN, the Network Director is responsible for the directors of the Edith Nourse Rogers Memorial Veterans Hospital, Manchester VA Medical Center, Providence VA Medical Center, VA Boston Healthcare System, VA Central Massachusetts Healthcare System, VA Connecticut Healthcare System, VA Maine Healthcare System, and the White River Junction VA Medical Center.

At the time of the OIG site visit, the executive leaders were permanently assigned and had been working together since December 2018 when the CMO assumed the position (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network director	September 2, 2018
Deputy network director	December 13, 2015
Chief medical officer	December 12, 2018
Quality management officer	February 19, 2017

Source: VA New England Healthcare System HRO (received June 4, 2019)

To help assess VISN executive leaders' engagement, the OIG interviewed the network director, acting deputy network director, CMO, and QMO regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The leaders are members of the VISN 1 Executive Leadership Council, which is responsible for processes for enhancing network performance, including:

- Organizational values and strategic direction
- Policy development and decision making
- Compliance and financial performance
- Creation and balancing of values for patients and other stakeholders
- Regular review of organizational performance and capabilities
- Priorities for improvement and opportunities for innovation
- Communication and development of organizational goals/objectives across the Network

The Executive Leadership Council, for which the network director serves as the chairperson, has oversight of various working groups, such as the Organizational Health, Quality Safety & Value, and Healthcare Operations Committees. While VISN 1 has several chartered councils that continue to meet regularly, the process for those councils to report to the Executive Leadership

Council through one of the four governance committees had not been finalized at the time of the OIG's review. See Figure 4.

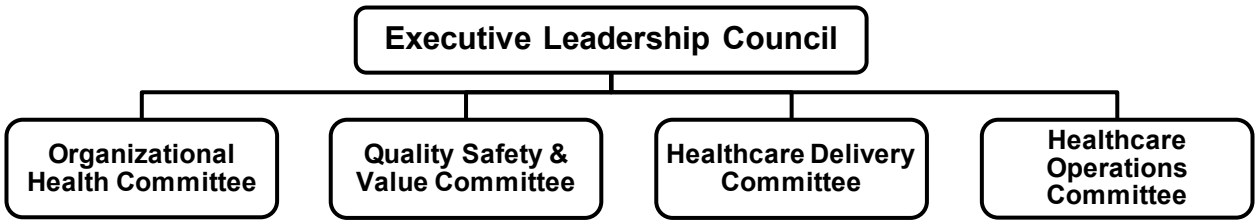

Figure 4. *VISN 1 Committee Reporting Structure*
Source: VA New England Healthcare System (received June 3, 2019)

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health. 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 VISN leadership.

To assess employee attitudes toward VISN leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018. Table 2 summarizes employee attitudes as expressed in VHA's All Employee Survey for VHA, the VISN Office, and VISN leaders.[9] The VISN Office averages for the selected survey questions were above the VHA averages.[10] The same trend was generally noted for the CMO and QMO; however, opportunities appeared to exist for the network director to improve employee satisfaction and for the deputy network director to model servant leadership.[11]

[9] Ratings are based on responses by employees who report to or aligned under the network director, deputy network director, CMO, and QMO.

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

[11] The network director scores are not reflective of the current network director who assumed the role after the survey was administered in June 2018.

Table 2. Survey Results on Employee Attitudes toward VISN Leadership (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	VISN Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: *Servant Leader Index Composite*[12]	0–100 where HIGHER scores are more favorable	71.7	79.3	51.3	58.3	89.3	87.9
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce?*	1 (Strongly Disagree)–5 (Strongly Agree)	3.3	3.6	2.9	3.3	4.0	4.3
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.8	3.1	3.7	4.3	4.4
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.8	3.4	3.6	4.1	4.3

Source: VA All Employee Survey (accessed May 3, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The VISN office averages were better than the VHA averages. However, it

[12] According to the 2018 VA All Employee Survey (AES) Questions by Organizational Health Framework, Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."

appeared that the network director, deputy network director, and CMO have opportunities to reduce employee moral distress at work.[13]

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	VISN Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.1	4.1	4.2	3.9	4.3
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	4.1	3.9	4.4	4.0	4.6
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.5	1.1	2.6	1.7	1.6	0.9

Source: VA All Employee Survey (accessed May 3, 2019)

[13] It is important to note that the network director and CMO scores are not reflective of the current leaders who assumed their roles after the survey was administered.

Patient Experience

To assess patient attitudes toward VISN and facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for VISN and facility leaders and compares the results to the overall VHA averages.[14]

VHA also collects SHEP survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward VISN and facility leaders (see Table 4). The VISN averages for each of the selected survey questions are above the VHA averages, indicating that VISN 1 patients are generally more satisfied compared to VHA patients in general. VISN 1 facility scores for the selected questions are presented in Appendix B.

Table 4. Survey Results on Patient Attitudes within VISN 1 (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA Average	VISN 1 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	74.3
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	88.6
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	83.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	82.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)

VHA also collects Inpatient, Patient-Centered Medical Home, and Specialty Care Survey SHEP data by gender. Over the last decade, the number of women using VA health care has nearly doubled, and it is expected that by 2020 women veterans will comprise nearly 11 percent of the

[14] Ratings are based on responses by patients who received care within the VISN.

total veteran population.[15] For this reason, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed responses to several relevant survey questions that reflect patients' attitudes toward VISN and facility leaders (see Tables 5–7). The VISN averages for both men and women respondents for each of the selected Inpatient, Patient-Centered Medical Home, and Specialty Care Survey questions are above the corresponding VHA averages, indicating that VISN 1 patients are generally more satisfied compared to VHA patients in general. VISN 1 facility scores for the selected questions are presented in Appendix B and note various opportunities for facility improvement.

Table 5. Inpatient Survey Results on Patient Attitudes within VISN 1 by Gender (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA		VISN 1	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	83.6	81.4	87.3	92.3
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	82.7	81.9	87.1	87.7
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	67.4	59.5	74.6	66.0

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 3, 2019)

[15] VHA. *Study of Barriers for Women Veterans to VA Health Care*, April 2015.

Table 6. Patient-Centered Medical Home Survey Results on Patient Attitudes within VISN 1 by Gender (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA		VISN 1	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.2	40.3	60.6	54.5
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	58.8	49.8	68.4	61.7
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.1	65.7	76.2	71.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 3, 2019)

Table 7. Specialty Care Survey Results on Patient Attitudes within VISN 1 by Gender (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA		VISN 1	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	47.6	43.2	56.6	57.5
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	55.2	50.7	64.4	57.5

Questions	Scoring	VHA		VISN 1	
		Male Average	Female Average	Male Average	Female Average
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	68.7	65.5	73.7	68.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 3, 2019)

During OIG interviews, VISN leaders cited several noteworthy endeavors and accomplishments meant to improve patient satisfaction and care provided to female veterans. First, VISN 1 has a dedicated patient experience officer who serves as the primary program manager and subject matter expert for VISN customer focused programs, including the Facilitated Listening Session Program, which provides opportunities to open the lines of communication between veterans and employees and gain an increased understanding or clarity on issues such as those captured in the SHEP survey data. As part of this program, the patient experience officer develops an annual schedule of listening sessions held throughout the fiscal year (FY), gathers information during those sessions, and prepares reports for leadership. Further, the Executive Leadership Council identified the "Veteran Experience" as one of the VISN's FY 2020 strategic objectives and approved this initiative on May 30, 2019.

Additionally, VISN 1 has provided maternity care coordination since 2014. These efforts were initially supported by an Office of Rural Health grant that allowed the hiring of a centralized registered nurse and social worker to provide maternity care coordination for all VISN 1 facilities. Although the grant was terminated in October 2015, VISN 1 leaders continued to support the program until the positions were permanently funded in September 2016. The maternity care coordination team serves to coordinate care between the pregnant patient, her local healthcare team, and the non-VA maternity provider. The team ensures that pregnant veterans receive access to services and medications that are needed during pregnancy and that the woman veteran returns to her VA primary care provider at three months after birth. This team has also conducted a comprehensive evaluation of the program by interviewing postpartum veterans who received VISN 1 maternity care coordination services. This evaluation is used to continuously improve services for pregnant veterans and to identify emerging issues for women veterans following pregnancy, such as postpartum depression. As of March 19, 2019, the program had 140 active participants.

Access to Care

VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[16] VHA has utilized various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates. Wait time measures based on "create date" do not rely upon the accuracy of the "preferred date" entered into the scheduling system and are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, that includes a "clinically indicated date." The disadvantage to "create date" metrics is that wait times do not account for specific patient requests/availability. Wait time measures based on patient preferred dates consider patient preferences but rely upon appointment schedulers accurately recording the patients' desired appointment dates into the scheduling software.

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA Choice Program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[17] However, with the passage of the VA MISSION Act of 2018 on June 6, 2018, and subsequent enactment on June 6, 2019,[18] eligibility criteria for obtaining care in the community now include average drive times and appointment wait-times:

- Average drive time
  - 30-minute average drive time for primary care, mental health, and noninstitutional extended care services
  - 60-minute average drive time for specialty care
- Appointment wait time
  - 20 days for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider

[16] According to VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures,* July 15, 2016 (amended July 12, 2019), the "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

[17] VHA Directive 1700, *Veterans Choice Program*, October 25, 2016.

[18] VA MISSION Act, https://missionact.va.gov/ (This website was accessed on June 27, 2019.)

- 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA health care provider

To assess access to primary and mental health care within VISN 1, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary care and mental health clinics for the most recently completed quarter. Tables 8 and 9 provide wait time statistics for completed primary care and mental health appointments from January 1, 2019, through March 31, 2019.

Table 8. Primary Care Appointment Wait Times[19] (January 1, 2019, through March 31, 2019)

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VISN 1: VA New England Healthcare System	5,145	15.2
Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA)	344	11.0
Manchester VA Medical Center (Manchester, NH)	566	15.1
Providence VA Medical Center (Providence, RI)	637	20.1
VA Boston Healthcare System (Boston, MA)	822	17.6
VA Central Western Massachusetts Healthcare System (Leeds, MA)	610	13.0
VA Connecticut Healthcare System (West Haven, CT)	971	8.8
VA Maine Healthcare System (Augusta, ME)	793	19.6
White River Junction VA Medical Center (White River Junction, VT)	402	16.0

Source: VHA Support Service Center (accessed May 3, 2019)

[19] Reported primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine, and records visits for comprehensive primary care services.

Table 9. Mental Health Appointment Wait Times[20]
(January 1, 2019, through March 31, 2019)

Facility	New Patient Appointments	Average New Patient Wait from Preferred Date
VISN 1: VA New England Healthcare System	1,311	9.2
Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA)	123	6.9
Manchester VA Medical Center (Manchester, NH)	111	7.8
Providence VA Medical Center (Providence, RI)	214	6.0
VA Boston Healthcare System (Boston, MA)	191	9.3
VA Central Western Massachusetts Healthcare System (Leeds, MA)	268	13.4
VA Connecticut Healthcare System (West Haven, CT)	79	10.4
VA Maine Healthcare System (Augusta, ME)	277	11.1
White River Junction VA Medical Center (White River Junction, VT)	48	3.0

Source: VHA Support Service Center (accessed May 3, 2019)

Based upon wait times alone, the MISSION Act may improve access to primary care for patients of Providence VA Medical Center, VA Boston Healthcare System (Boston, MA), and VA Maine Healthcare System (Augusta, ME) where the average wait time for primary care appointments is near or above 20 days. However, the wait times also highlight opportunities for these facilities to improve the timeliness of primary care provided "in house" and thus decrease the potential for fragmented care among those who are referred to community providers.

Clinician Vacancies

Within the healthcare field, there is general acceptance that staff turnover, or instability, and high clinical vacancy rates negatively impact access to care, quality of health care provided, patient safety, and patient and staff satisfaction. Turnover can directly affect staffing levels and further reduce staff and organizational performance through the loss of experienced staff.[21]

To assess the extent of clinical vacancies across VISN 1 facilities, the OIG requested and reviewed the number of overall vacancies (all position types) by facility, position,

[20] Reported mental health wait times are for appointments designated as clinic stop 502 (Mental Health Clinic Individual) and records visits for the evaluation, consultation, and/or treatment by staff trained in mental diseases and disorders.

[21] J. Buchanan. Reviewing the Benefits of Health Workforce Stability. *Human Resources for Health* (2010): 8–29; VHA Research Series: *The Business Case for Work Force Stability* (2002).

service/section, and full-time equivalents (FTE). Table 10 provides the vacancy rates across the VISN for all position types as of May 15, 2019.

Table 10. Reported Vacancy Rates for VISN 1 Facilities (as of May 15, 2019)

Facility	Vacant FTE	Total Onboard FTE	Vacancy Percentage
Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA)	222.8	1444.9	13.4
Manchester VA Medical Center (Manchester, NH)	125.0	945.3	11.7
Providence VA Medical Center (Providence, RI)	199.2	1462.5	12.0
VA Boston Healthcare System (Boston, MA)	415.2	4532.4	8.4
VA Central Western Massachusetts Healthcare System (Leeds, MA)	144.4	1004.8	12.6
VA Connecticut Healthcare System (West Haven, CT)	406.6	2945.0	12.1
VA Maine Healthcare System (Augusta, ME)	238.5	1486.1	13.8
White River Junction VA Medical Center (White River Junction, VT)	220.2	1161.6	15.9

Source: VA New England Healthcare System HRO (received June 5, 2019)

Upon closer inspection, the OIG found many clinical vacancies across VISN 1 for physicians (~100 FTE), nurses (>300 FTE), nursing assistants (>100 FTE), and practical nurses (>75 FTE). The VISN HRO acknowledged difficulties in offering salaries competitive with the private sector and stated that this is a general recruitment challenge for VHA. However, the HRO also discussed ways in which the VISN promotes its facilities to clinicians seeking employment, including offering research opportunities and affiliations with prestigious universities and the use of the Education Debt Reduction Program.[22]

Given the potential opportunities to improve primary care wait times at Providence VA Medical Center, VA Boston Healthcare System (Boston, MA), and VA Maine Healthcare System (Augusta, ME), the OIG also reviewed the number of primary care provider vacancies at these facilities (see Table 11).[23] With vacancy rates ranging from 7.8 to 12.4 percent, provider staffing did not appear to be a significant contributing factor for primary care wait time challenges.

[22] VA's Education Debt Reduction Program is a reimbursement program for educational debt, such as tuition, fees, and books for qualifying employees who are in specific, hard-to-recruit direct patient care positions.

[23] Vacancy rates are based upon physician, physician assistant, and nurse practitioner position types.

Table 11. Estimated Primary Care Provider Vacancy Rates for Selected Facilities (as of June 6, 2019)

Facility	Vacant FTE	Total Provider FTE	Vacancy Percentage
Providence VA Medical Center (Providence, RI)	5.0	40.3	12.4
VA Boston Healthcare System (Boston, MA)	4.0	51.1	7.8
VA Maine Healthcare System (Augusta, ME)	2.9	46.9	6.2

Source: VA New England Healthcare System HRO (received June 6, 2019)

VISN Efforts to Reduce Veteran Suicides

Suicide is a leading cause of death in the United States, and suicide rates in almost all states increased from 1999 through 2016.[24] Although the unadjusted rate of suicide among veterans decreased from 30.5 to 30.1 per 100,000 veterans from 2015 to 2016, the suicide rate for veterans age 18–34 has risen substantially since 2005. With approximately 20 million veterans in United States, the number of veterans who die by suicide annually is significant.[25] Further, the issue of suicide has garnered recent Congressional and media interest, given the suicides of three veterans at VA facilities in Georgia and Texas within five days of each other in April 2019.

Interviewed leaders were knowledgeable about efforts taken to reduce veteran suicide in VISN 1 and shared various data that highlighted those efforts. This included implementation of the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment (REACH VET) program, which uses predictive models to identify veterans whose care should be enhanced. The program uses "data from Veterans' health records to identify those at a statistically elevated risk for suicide, hospitalization, illness or other adverse outcomes. This allows VA to provide pre-emptive care and support for Veterans, in some cases before a Veteran even has suicidal thoughts."[26] VISN 1 data showed steady improvement during FY 2019 through March 13, 2019, for percent of REACH VET pre-emptive care attempts. Statistics for the same time frame also show that facility-level suicide prevention coordinators are meeting or exceeding VISN goals for providing community outreach events.

[24] The Centers for Disease Control and Prevention. *CDC Vitalsigns*™, June 2018. https://www.cdc.gov/violenceprevention/suicide/datasources.html. (The website was accessed on April 12, 2019.)

[25] Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005–2016*, September 2018.

[26] Office of Public and Intergovernmental Affairs, *VA REACH VET Initiative Helps Save Veterans Lives: Program Signals When More Help Is Needed for At-risk Veterans*, April 3, 2017.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. Except for those made in recently published reports, VISN and facility leaders have closed all recommendations for improvement listed in Appendix C.[27]

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[28]

VA also uses a star rating system where VISNs and facilities with a "5-star" rating are performing within the top 10 percent and "1-star" VISNs and facilities are performing within the bottom 10 percent. As of June 30, 2018, VISN 1 was rated at "4-star" for overall quality. Table 12 summarizes the SAIL star ratings for facilities within the VISN.

[27] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations.

[28] VHA Support Service Center (VSSC), *the Strategic Analytics for Improvement and Learning (SAIL) Value Model*, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Table 12. VISN 1 Facility SAIL Star-Ratings for Overall Quality (as of June 30, 2018)

Facility	Star Rating
Edith Nourse Rogers Memorial Veterans Hospital	5
Manchester VAMC (Manchester, NH)	3
Providence VAMC (Providence, RI)	3
VA Boston HCS (Jamaica Plain, MA)	4
VA Central Western Massachusetts HCS (Leeds, MA)	5
VA Connecticut HCS (West Haven, CT)	5
VA Maine HCS (Augusta, ME)	5
White River Junction VAMC (White River Junction, VT)	3

Source: VHA Support Service Center (accessed May 3, 2019)

Figure 5 illustrates the VISN's quality of care and efficiency metric rankings and performance as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of registered nurse (RN) turnover, healthcare (HC) associated infections, rating (of) hospital, best place to work, and mental health (MH) continuity (of) care). Metrics that need improvement are denoted in orange and red (for example, physician capacity, acute care in-hospital standardized mortality ratio (SMR), and adjusted length of stay (LOS)).[29]

[29] For information on the acronyms in the SAIL metrics, please see Appendix D.

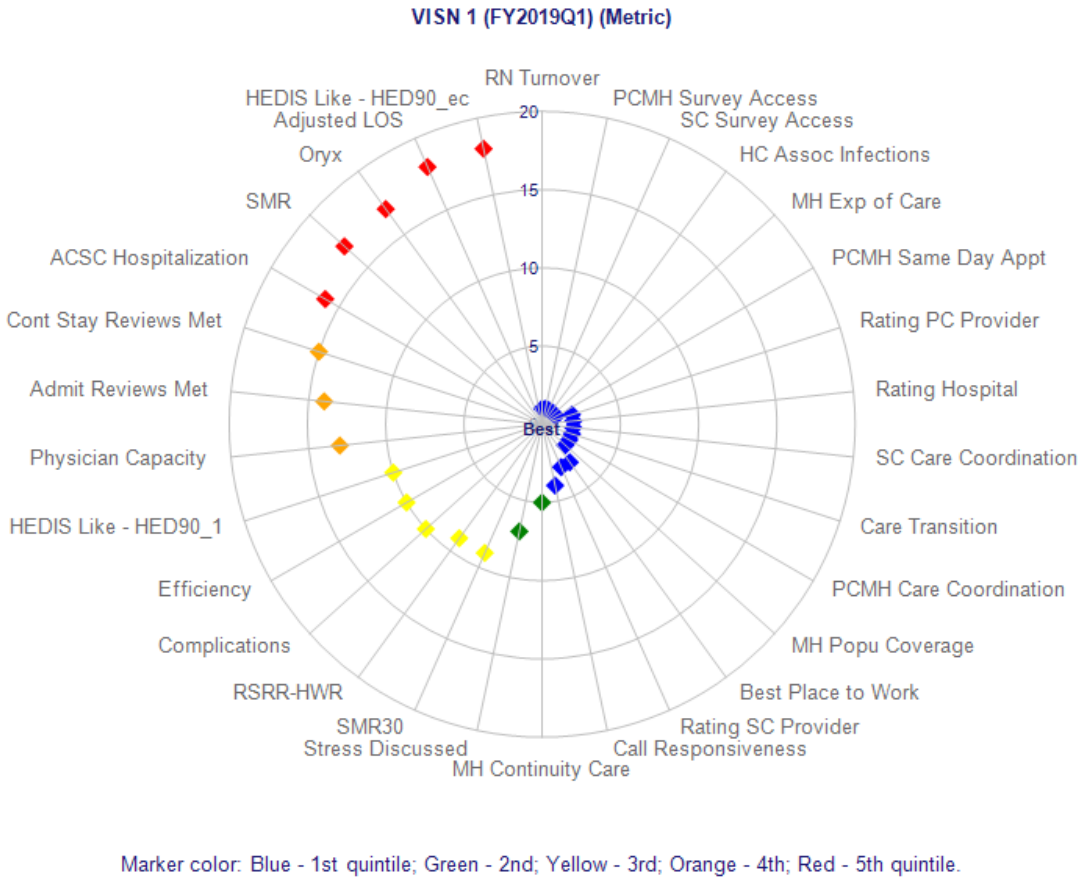

Figure 5. *VISN 1 Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix D.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[30] The SAIL CLC provides a single resource to review quality measures and health inspection results. It includes

[30] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, November 19, 2018, "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several 'star' ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

star ratings for unannounced survey, staffing, quality, and overall results.[31] Table 13 summarizes the star-ratings for facility CLCs within the VISN as of December 31, 2018.

Table 13. VISN 1 Facility SAIL CLC Star-Ratings (as of December 31, 2018)

Facility	Unannounced Survey Star Rating	Staffing Star Rating	Quality Star Rating	Overall Star Rating
Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA)	5	5	3	5
Manchester VAMC (Manchester, NH)	3	5	4	4
VA Boston HCS (Brockton, MA)	1	5	1	1
VA Central Western Massachusetts HCS (Leeds, MA)	3	5	3	4
VA Connecticut HCS (West Haven, CT)	4	5	2	5
VA Maine HCS (Augusta, ME)	1	5	1	1

Source: VHA Support Service Center (accessed May 3, 2019)

The SAIL CLC also includes a radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 6 illustrates the VISN's quality measure rankings and performance for VISN facility CLCs' performance compared with other CLCs as of December 31, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of high risk pressure ulcer–long stay (LS) and new or worse pressure ulcer (PU)–short-stay (SS)). Measures that need improvement are denoted in orange and red (for example, ability to move independently worsened (LS), urinary tract infections (UTI)–LS, and falls with major injury (LS)).[32]

[31] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019, but is not accessible by the public.)

[32] For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

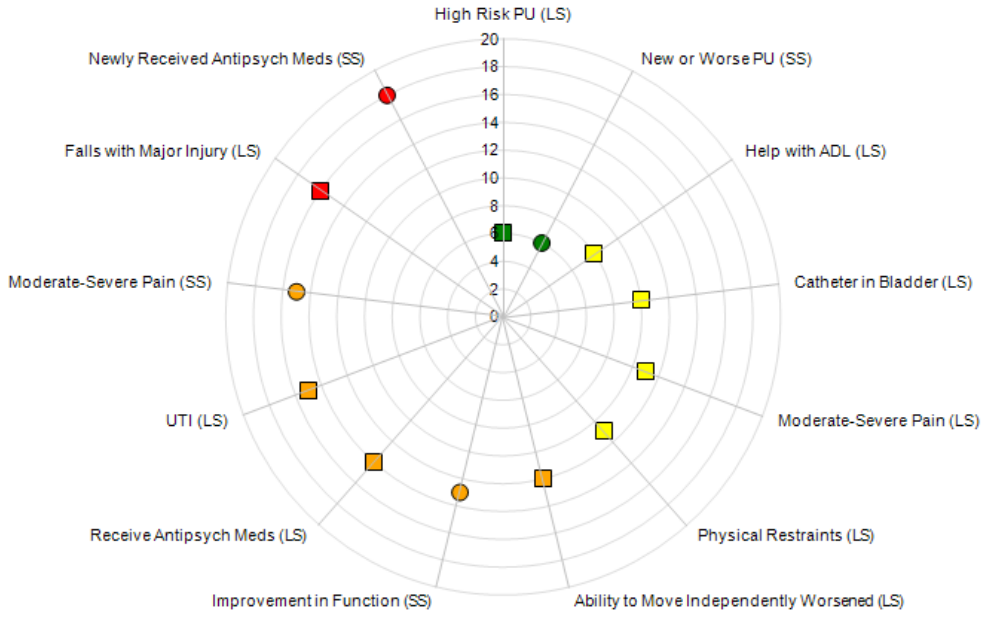

Figure 6. *VISN 1 SAIL CLC Quality Metric Rankings (as of December 31, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Although the CMS *Nursing Home Compare* results (Table 13) are positive for most of the VISN 1 CLCs, the VA Boston and VA Maine HCS CLCs both received "1-star" for quality and overall ratings. Further, the performance of VISN 1 CLCs relative to all other CLCs (VA internal comparison) for all 13 quality measures (Figure 6) demonstrate multiple opportunities for improvement. The network director and CMO reportedly added a new strategic initiative to focus on CLC performance and initiated internal mock reviews performed by multidisciplinary VISN 1 CLC staff using Long Term Care Institute criteria.[33]

Leadership and Organizational Risks Conclusion

The VISN 1 leadership team appeared stable, with all positions permanently filled for approximately six months prior to the OIG's on-site visit. Selected survey scores related to employee satisfaction and attitudes toward the workplace were generally better than the VHA averages. However, opportunities appear to exist for the network director to improve employee

[33] The Long-Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and over 1,145 external regulatory surveys since 1999. The Long-Term Care Institute is "focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings." Long Term Care Institute. http://www.ltciorg.org/about-us/. (The website was accessed on March 6, 2019.)

satisfaction; the deputy network director to model servant leadership; and the network director, deputy network director, and CMO to reduce employee moral distress at work.[34]

In review of patient experience survey data, the OIG noted VISN averages for each of the selected survey questions are above the VHA averages, indicating that VISN 1 patients are generally more satisfied compared to all VHA patients in general. VISN leaders also supported efforts to provide accessible and inclusive care for women veterans. The OIG's review of access metrics and clinician vacancies did not identify any significant organizational risks. Although interviewed leaders appeared knowledgeable about efforts taken to reduce veteran suicide as well as selected SAIL and CLC performance metrics, they should continue to support facility actions to improve care provided throughout VISN 1.

[34] It is important to note that the network director and CMO scores are not reflective of the current leaders who assumed their roles after the survey was administered.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk aware, and committed to consistently providing quality care, while seeking continuous improvement.[35] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[36] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[37]

In determining whether the VISN implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, the OIG evaluated the following VISN-level performance indicators:[38]

- Standing VISN committee with responsibility for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the VISN director
  - Reviewed aggregated QSV data and took necessary actions
- Completion of at least 75 percent of all required inpatient reviews
- Collection, analysis, and action, as appropriate, in response to VISN peer review data

The OIG also interviewed VISN managers and evaluated relevant documents when concurrent VISN 1 facility CHIP reviews identified trends in noncompliance.

Quality, Safety, Value Conclusion

The OIG found general compliance with requirements related to a standing VISN committee with responsibility for key QSV functions and the collection, analysis, and action taken in response to VISN peer review data. However, the OIG identified a concern with the completion

[35] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value,* August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded on October 24, 2019.)

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

[37] VHA Directive 1026.

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

of required inpatient stay reviews and trends in noncompliance with utilization management and root cause analyses at two or more VISN 1 facilities during concurrent facility CHIP reviews that warranted recommendations for improvement.

Specifically, VHA requires that the network director ensures that "VISN facilities are conducting a minimum of 75 percent of acute inpatient stay reviews unless a waiver to perform a sample has been granted by the NUMAC [National Utilization Management Advisory Committee],"[39] and, as of April 30, 2019, VHA has increased the minimum requirement to 80 percent.[40] The OIG found that from April 1, 2018, through March 31, 2019, VA Central Western Massachusetts Healthcare System completed 44 percent of required inpatient stay reviews and Providence VA Medical Center completed 70 percent. This resulted in a lack of assurance that inpatient admissions and continued stays were appropriate at the specified level of care. The VISN QMO cited clinical vacancies in the quality management department at both facilities as the reason for noncompliance.

Recommendation 1

1. The network director ensures that staff at each Veterans Integrated Service Network facility perform the required acute inpatient stay reviews and monitors staff compliance.

VISN concurred.

Target date for completion: June 30, 2020

VISN response: The VISN Quality Management Officer established a process in which facility utilization management nurses meet monthly to review challenges and opportunities for improvement including data demonstrating the percent of review completed by each facility. This facility level data is also reviewed monthly by VISN leadership and facility leadership during the monthly performance review meetings for oversight and any needed intervention. VISN level data is reviewed by the VISN Quality Safety and Value Committee with a report provided to the Executive Leadership Council. The minutes of the Executive Leadership Council are signed by the Network Director. Evidence to demonstrate achievement will be 6 consecutive months with 90% completion of the required acute inpatient stay reviews.

VHA requires an ongoing review of utilization management data by an interdisciplinary group that includes "representatives from UM [utilization management], Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R–UR [chief business office revenue-

[39] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (This directive expired on July 31, 2019.), "the National Utilization Management Advisory Committee (NUMAC) is responsible for oversight and monitoring of VHA's UM Program."

[40] VHA Directive 1117(2).

utilization review]."[41] The OIG found that an interdisciplinary group did not review utilization management data at VA Central Western Massachusetts Healthcare System and that four of the required members did not review utilization management data at Edith Nourse Rogers Memorial Veterans Hospital in the past 12 months. This may delay the identification of trends, outcomes, and opportunities for program improvement. The VISN QMO informed the OIG that the patient safety manager at VA Central Western Massachusetts Healthcare System was removed about four weeks prior to the OIG visit and that the patient safety manager at Edith Nourse Rogers Memorial Veterans Hospital is new to the role and had been in the position about one year.

Recommendation 2

2. The quality management officer confirms that an interdisciplinary group at each facility reviews utilization management data and monitors the group's compliance.

VISN concurred.

Target date for completion: September 30, 2020

VISN response: The VISN Quality Management Officer met with the facility Quality Managers to develop a standard process for confirmation that an interdisciplinary group with the required membership attendance, reviews facility level utilization management data. The process includes quarterly submission of facility level group meeting minutes to include attendance and data reviewed. These submissions will be reviewed for trends by the VISN Quality Management Officer and reported annually to the VISN Quality Safety and Value Committee with subsequent report to the VISN Executive Leadership Council. Evidence of completion will be demonstrated when each facility submits minutes of the interdisciplinary committee meeting showing utilization management data review for 2 consecutive quarters.

VHA also requires staff to annually complete a minimum of eight root cause analyses.[42] The OIG found that staff at VA Central Western Massachusetts Healthcare System completed none of the required root cause analyses, and staff at Edith Nourse Rogers Memorial Veterans Hospital completed two in FY 2018. This resulted in missed opportunities to identify process improvements that may reduce the recurrence of adverse events. The VISN QMO stated that the patient safety manager at VA Central Western Massachusetts Healthcare System was removed about four weeks prior to the OIG visit and that the patient safety manager at Edith Nourse

[41] According to VHA Directive 1117(2), Utilization management reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria."

[42] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

Rogers Memorial Veterans Hospital is new to the role and had been in the position about one year.

Recommendation 3

3. The quality management officer makes certain that staff at each facility annually complete a minimum of eight root cause analyses and monitors staff compliance.

VISN concurred.

Target date for completion: September 30, 2020

VISN response: The VISN Quality Management Officer will receive a quarterly report from the VISN Patient Safety Officer documenting the number of completed RCAs per facility. This report will be reviewed by the Quality Management Officer and an annual patient safety report including RCA completion rates will be provided to the VISN Quality Safety and Value Committee. The Committee is co-chaired by the Quality Management Officer who also signs the minutes.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[43]

VHA also requires network directors to "maintain an appropriate credentialing and privileging process consistent with the VHA policy" and specifically charges VISN chief medical officers with "oversight of the credentialing and privileging process of the facilities within the VISN."[44]

The OIG interviewed VISN managers and reviewed relevant documents when concurrent VISN 1 facility CHIP reviews identified trends in noncompliance.

Medical Staff Privileging Conclusion

The OIG identified trends in noncompliance during CHIP reviews related to focused professional practice evaluations (FPPEs), ongoing professional practice evaluations (OPPEs), and FPPEs for cause that warranted recommendations for improvement.[45]

Specifically, VHA requires FPPEs to have evaluation criteria defined in advance.[46] The OIG identified noncompliance for defining FPPE criteria in advance at Central Western Massachusetts Healthcare System, Edith Nourse Rogers Memorial Veterans Hospital, and Manchester VA Medical Center. Failure to clearly define criteria in advance may result in providers' unclear expectations and hinder evaluation and privileging. The deputy CMO reported the lack of a systematic process and staffing changes as reasons for noncompliance at VA Central Western Massachusetts Healthcare System and was unaware of reasons for

[43] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

[44] VHA Handbook 1100.19.

[45] The definitions of ongoing professional practice evaluation and focused professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2). An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety." A focused professional practice evaluation is "a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility." A focused professional practice evaluation for cause is "a time-limited period during which the medical staff leadership assesses the provider's professional performance to determine if any action should be taken on the provider's privileges."

[46] VHA Handbook 1100.19.

noncompliance at Edith Nourse Rogers Memorial Veterans Hospital and Manchester VA Medical Center.

Recommendation 4

4. The chief medical officer ensures that facility clinical managers define criteria in advance for licensed independent practitioners' focused professional practice evaluations and monitors clinical managers' compliance.

VISN concurred.

Target date for completion: January 2021

VISN response: The Chief Medical Officer will communicate to facility clinical managers through Chiefs of Staff the requirements to define initial focused professional practice evaluation (FPPE) criteria and communicate these with licensed independent practitioners (LIP) at the onset of the FPPE period. Initial FPPE templates have been requested from clinical services from all facilities and the Chief Medical Officer will require all initial FPPE templates to include a signature box to document the date that the FPPE criteria were reviewed with the LIP.

The Chief Medical Officer or designee will complete a monthly audit, collecting a sample of initial FPPE forms that were initiated within the previous month from each VAMC (two per VAMC, for 16 total each month) and completing an audit checklist that documents for each sampled LIP: the presence of criteria for the FPPE evaluation; and date that the LIP was informed of the criteria. A formal summary report will be generated, signed by the Chief Medical Officer and submitted to the Quality Management Officer along with the compiled audit checklists. The goal for completion is 6 consecutive months with 90% of reviewed FPPEs including both specific criteria and LIP informed of the criteria.

VHA requires OPPEs to have service-specific criteria and results that are based on evaluation by another provider with similar training and privileges. In addition, VHA requires the executive committee of the medical staff to document the decision to recommend continuing privileges for licensed independent practitioners based on OPPE results.[47] The OIG found that OPPEs at Edith Nourse Rogers Memorial Veterans Hospital and Manchester VA Medical Center did not consistently contain service-specific criteria or have results based on evaluation by another provider with similar training and privileges. The OIG also found that the executive committee of the medical staff did not document the decision to recommend continuing privileges for licensed independent practitioners at the Manchester VA Medical Center or VA Central Western Massachusetts Healthcare System. As a result, licensed independent practitioners continued to deliver care without a thorough evaluation of their practice. The deputy chief medical officer reported the lack of a systematic process and staffing changes as reasons for noncompliance at

[47] VHA Handbook 1100.19.

VA Central Western Massachusetts Healthcare System and was unaware of reasons for noncompliance at Edith Nourse Rogers Memorial Veterans Hospital and Manchester VA Medical Center.

Recommendation 5

5. The chief medical officer confirms that facility clinical managers include service-specific criteria in ongoing professional practice evaluations for licensed independent practitioners and monitors clinical managers' compliance.

VISN concurred.

Target date for completion: January 2021

VISN response: The Chief Medical Officer will communicate to facility clinical managers through Chiefs of Staff the requirements to define service-specific criteria in all ongoing professional practice evaluation (OPPE). OPPE templates have been requested from clinical services from all facilities and the Chief Medical Officer will require all OPPE templates to include service-specific criteria.

The Chief Medical Officer or designee will complete a monthly audit, collecting a sample of OPPE forms of LIPs who completed re-privileging within the previous month from each VISN 1 facility (two per facility, for 16 total each month) and completing an audit checklist that documents for each sampled LIP: the presence of service-specific criteria used during the OPPE evaluation. A formal summary report will be generated, signed by the Chief Medical Officer and submitted to the Quality Management Officer along with the compiled audit checklists. The goal for completion is 6 consecutive months with 90% of reviewed OPPEs compliant in the use of service-specific criteria.

Recommendation 6

6. The chief medical officer confirms that ongoing professional practice evaluation results are based on evaluation by another provider with similar training and privileges and monitors compliance.

VISN concurred.

Target date for completion: January 2021

VISN response: The Chief Medical Officer will communicate to facility clinical managers through Chiefs of Staff the requirements to base OPPE results on an evaluation completed by another LIP with similar training and privileges (heretofore referenced to as a "peer LIP"). OPPE templates have been requested from clinical services from all facilities and the Chief Medical Officer will require all OPPE templates to include: a listing of the privileges held by the "reviewed LIP" that are being evaluated through the OPPE process; and an attestation signature box completed by the peer LIP, attesting that the LIP has similar training and privileges to the reviewed LIP. The Chief Medical Officer will continue to facilitate inter-facility or inter-VISN partnership to ensure that appropriate peer LIPs are available to complete OPPEs for LIPs with uncommon privileges.

The Chief Medical Officer or designee will complete a monthly audit, collecting a sample of OPPE forms of LIPs who completed re-privileging within the previous month from each VAMC (two per VAMC, for 16 total each month) and completing an audit checklist that documents for each sampled LIP: a listing of the reviewed LIP's active privileges on the OPPE form; and an attestation signature by the peer LIP that attests the peer as a provider with similar training and privileges. In addition, the Chief Medical Officer or designee will contact VAMC Credentialing offices to request a list of privileges for a sample of the peer LIPs who completed OPPE evaluations (25%, or 4 peer LIPs per month) to secondarily confirm data to support the attestations. A formal summary report will be generated, signed by the Chief Medical Officer and submitted to the Quality Management Officer along with the compiled audit checklists. The goal for completion is 6 consecutive months with 90% of reviewed LIPs demonstrating evidence that OPPE results were based on an evaluation by a provider with similar training and privileges.

Recommendation 7

7. The chief medical officer verifies that facilities' executive committee of the medical staff document the decision to recommend continuing privileges for licensed independent practitioners based on ongoing professional practice evaluation results and monitors committees' compliance.

VISN concurred.

Target date for completion: January 2021

VISN response: The Chief Medical Officer will communicate to facilities' executive committees of the medical staff (ECMS) through Chiefs of Staff, the requirements to document the decision to recommend continuing privileges for LIPs based on OPPE results. The Chief Medical Officer will require ECMS templates documenting re-privileging recommendations to include a reference to OPPE review.

The CMO or designee will complete a monthly audit, collecting ECMS re-privileging documents for a sample of LIPs who completed re-privileging within the previous month from each VAMC (two per VAMC, for 16 total each month) and completing an audit checklist that documents for each sampled LIP: a reference in ECMS documentation to OPPE results. A formal summary report will be generated, signed by the CMO and submitted to the Quality Management Officer along with the compiled audit checklists. The goal for completion is 6 consecutive months with 90% of reviewed ECMS documents containing reference to OPPE results.

VHA requires FPPEs for cause to be time-limited, have clearly defined expectations and outcomes, and involve the advanced sharing of details with the provider.[48] The OIG found that FPPEs for cause did not consistently include clearly defined expectations, outcomes, and time frames that were shared in advance with licensed independent practitioners at VA Central Western Massachusetts Healthcare System and Edith Nourse Rogers Memorial Veterans Hospital. As a result, licensed independent practitioners continued to deliver care without a thorough evaluation of the clinical concern identified. The deputy chief medical officer reported the lack of a systematic process and staffing changes as reasons for noncompliance at VA Central Western Massachusetts Healthcare System and was unaware of reasons for noncompliance at Edith Nourse Rogers Memorial Veterans Hospital.

Recommendation 8

8. The chief medical officer makes certain that facility clinical managers clearly define and share in advance the expectations, outcomes, and time frames with licensed independent practitioners for focused professional practice evaluations for cause and monitors clinical managers' compliance.

[48] Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2).

VISN concurred.

Target date for completion: January 2021

VISN response: The Chief Medical Officer will communicate to facility clinical managers through Chiefs of Staff the requirements to clearly define for all FPPE for cause (i.e., "triggered FPPE") the expectations, outcomes and timeframe for successful completion of the FPPE, and to document that these factors were communicated to the LIP at the beginning of the FPPE period. The Chief Medical Officer will require all triggered FPPE templates to include fields to document expectations, outcomes and timeframe, as well as a LIP signature box to document the date that the FPPE elements were communicated to the LIP.

The Chief Medical Officer or designee will complete a monthly audit, collecting a sample of triggered FPPE forms initiated during the previous month from each VAMC (up to two per VAMC, for 16 maximum each month) and completing an audit checklist that documents for each sampled LIP: documentation of expectations, outcome and timeframe for the FPPE evaluation; and date that the LIP was informed of the FPPE elements. A formal summary report will be generated, signed by the Chief Medical Officer and submitted to the Quality Management Officer along with the compiled audit checklists. The goal for completion is 6 consecutive months with 90% of reviewed FPPEs including expectations, outcome, timeframe and LIP signature.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[49]

The OIG interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, the OIG evaluated the following VISN-level performance indicators:[50]

- Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee[51]
  - Met at least quarterly
  - Documented an annual review of the VISN Emergency Operation Plan within the previous 12 months
  - Documented an annual review of the VISN Continuity of Operation Plan within the previous 12 months
  - Documented an annual review of the VISN Hazard Vulnerability Analysis within the previous 12 months
  - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leadership for review and approval
- Assessment of inventory management programs through a quality control review once per FY[52]

The OIG also interviewed VISN managers and reviewed relevant documents when concurrent facility-level CHIP reviews within the VISN identified trends in noncompliance.

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[49] VHA Directive 1608, *Comprehensive Environment of Care (CEOC Program)*, February 1, 2016.

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

[51] VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[52] VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016 (amended October 26, 2018).

Environment of Care Conclusion

The OIG found evidence of an annual inventory management program assessment through a quality control review. The OIG noted limited trends during facility CHIP inspections related to dirty floors in patient care areas at Manchester VA Medical Center, Edith Nourse Rogers Memorial Veterans Hospital, and VA Central Western Massachusetts Healthcare System and stained ceiling tiles in patient care areas at Manchester VA Medical Center and Edith Nourse Rogers Memorial Veterans Hospital that did not rise to the level of a recommendation. However, the OIG identified noncompliance with the VISN comprehensive environment of care policy and emergency management committee that warranted recommendations for improvement.

Specifically, VHA requires VISNs to have "a written policy that establishes and maintains a CEOC [comprehensive environment of care] Program at the VISN level."[53] The OIG found that a draft policy had been developed in July 2016, however, it had not been finalized or approved by VISN leadership. This resulted in missed opportunities to "promote consistent operation of the CEOC program by establishing program oversight, performance, and accountability standards that can be monitored at all levels of VHA."[54] The capital assets manager cited lack of oversight and personnel changes as the reasons for noncompliance.

Recommendation 9

9. The deputy network director ensures a written policy establishes and maintains a Veterans Integrated Service Network-level comprehensive environment of care program.

VISN concurred.

Target date for completion: February 2020

VISN response: In order to ensure the identified issue has been addressed an updated Environment of Care policy was reviewed and approved by the Healthcare Operations Committee on November 1, 2019. The deputy network director is co-chair of Healthcare Operations Committee and co-signs minutes. The updated environment of care program policy will be an agenda item on the Executive Leadership Council meeting scheduled for January 9, 2020. Going forward, the policy will be updated in accordance with VHA guidance governing local policies.

VHA requires VISN directors to establish an emergency management committee that meets at least quarterly. The emergency management committee is then responsible for "conducting an annual review of the VISN office EOP [Emergency Operations Plan], Continuity of Operations

[53] VHA Directive 1608.
[54] VHA Directive 1608.

Plan (COOP), and Hazards Vulnerability Analysis (HVA);" and conducting, documenting, and sending an annual review of the "collective VISN-wide strengths, weaknesses, priorities and requirements for improvement…to VISN leadership for review and approval."[55] Although the OIG found that the VISN leaders established an emergency management committee, the committee did not have evidence of an annual review of the (1) VISN office EOP, COOP, and HVA or (2) the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement which should have been sent to VISN leaders for review and approval. This resulted in a potential lack of readiness for the management of emergency incidents. The emergency management coordinator reported that the emergency management committee verbally discussed the EOP, COOP, HVA, and annual assessment regarding strengths and weaknesses; however, the emergency management coordinator cited the VISN's abrupt network director transition and the change in VISN governance committees, which disrupted routine annual emergency management program briefings, as the reasons for noncompliance.

Recommendation 10

10. The deputy network director makes certain that the emergency management committee conducts an annual review of the emergency operations plan, continuity of operations plan, and hazards vulnerability analysis and monitors the committee's compliance.

VISN concurred.

Target date for completion: February 2020

VISN response: To ensure the identified issue has been addressed the VISN 1 Emergency Management Committee conducted an Annual Review at the Face to Face meeting of the VISN 1 Emergency Management Committee on October 17, 2019. During the annual review, each facility reviewed their Emergency Operations Plan, Continuity of Operations Plan, Hazardous Vulnerability Analysis, and Comprehensive Emergency Management Program analysis. The Annual Review Report will be presented to the VISN 1 Healthcare Operations Committee in December of 2019 and repeated in December annually thereafter. Minutes co-signed by the deputy network director will document the continued compliance of annual activity of the emergency management committee.

[55] VHA Directive 0320.01.

Recommendation 11

11. The deputy network director makes certain that the emergency management committee conducts, documents, and sends an annual review of the collective Veterans Integrated Service Network-wide strengths, weaknesses, priorities, and requirements for improvement to leadership for review and approval and monitors the committee's compliance.

VISN concurred.

Target date for completion: February 2020

VISN response: On October 17, 2019 at their annual Face to Face meeting the VISN 1 Emergency Management Committee conducted an Annual Review. Data from all VISN 1 facilities (to include but not limited to: Hazardous Vulnerability Assessments, Continuity of Operations Plans, Comprehensive Emergency Management Program reviews, After Action Reports, and direct input from every VHA emergency management professional in VISN 1 will be included in the cumulative data report. Included in the report will be also be submissions from each facility regarding their strengths, weaknesses, and areas of improvement. The Annual Review Report will be presented to the VISN 1 Healthcare Operations Committee, with minutes co-signed by the deputy network director, in December of 2019. The Healthcare Operations Committee will present the annual report to the VISN 1 Executive Leadership Council in January of 2020. Once presented and approved by the VISN 1 Executive Leadership Council the report will be signed by the VISN 1 Director.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative potential for abuse, and likelihood of causing dependence if abused.[56] Diversion of controlled substances by healthcare workers—the transfer of a legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare organizations.[57]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. VHA also requires VISN and facility quality managers to review controlled substances inspection quarterly trend reports to ensure adherence with program requirements and that facilities take corrective actions when needed.[58]

The OIG interviewed VISN managers and reviewed relevant documents to assess whether the QMO reviewed facilities' controlled substances inspection quarterly trend reports and when concurrent facility-level CHIP reviews identified trends in noncompliance.

Medication Management Conclusion

The OIG did not identify any trends during facility CHIP reviews within the VISN. However, the OIG identified noncompliance with the VISN review of facilities' controlled substances inspection quarterly trend reports that warranted a recommendation for improvement.

Specifically, VHA requires VISN QMOs to review facilities' controlled substances inspection quarterly trend reports and ensure facilities take corrective actions, when needed.[59] The OIG found that the QMO did not review facilities' controlled substances inspection quarterly trend reports within the previous 12 months. As a result, there were missed opportunities to ensure facilities' compliance with the controlled substances inspection program. The QMO reported being unaware of the requirement and acknowledged that results are not compiled, trended, or reported to VISN leadership.

[56] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (The website was accessed on March 7, 2019.)

[57] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists,* 74, no. 5 (March 1, 2017): 325-348.

[58] VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

[59] VHA Directive 1108.02(1).

Recommendation 12

12. The quality management officer reviews Veterans Integrated Service Network facilities' controlled substances inspection quarterly trend reports.

VISN concurred.

Target date for completion: September 30, 2020

VISN response: The VISN Quality Management Officer in conjunction with the facility Controlled Substance Coordinators reviewed the existing process for quarterly reporting of controlled substance inspection program reports and developed a standard reporting template to be used at all 8 facilities. These standard templates are completed by the facility within 30 days of the end of each quarter and submitted to the VISN. Timely compliance to the submission requirement is tracked through an established task tracking process. The quarterly reports are then compiled and analyzed for trends. The compiled report and any identified trends are reported to the VISN Quality Safety and Value Committee with minutes signed by the VISN Quality Management Officer. Signed meeting minutes documenting presentation of results for 2 consecutive quarters will document sustained oversight.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Findings

The intent is for VISN leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinician vacancies • VISN efforts to reduce veteran suicides • Oversight inspections • VHA performance data	Twelve OIG recommendations, ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events, are attributable to the network director, deputy network director, CMO, and QMO. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Quality, Safety, and Value	• Standing VISN committee with responsibility for key QSV functions
	• Completion of at least 75 percent of all required inpatient reviews
	• Collection, analysis, and action, as appropriate, in response to VISN peer review data
	• Facility-level CHIP indicators:
	  ○ Protected peer reviews
	  ○ UM reviews
	  ○ Patient safety
	  ○ Resuscitation episode review
		• None	• Staff at each VISN facility perform the required acute inpatient stay reviews.
			• An interdisciplinary group at each facility reviews UM data.
			• Staff at each facility annually complete a minimum of eight root cause analyses.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Medical Staff Privileging	• Facility-level CHIP indicators:
	  ○ Privileging
	  ○ FPPEs
	  ○ OPPEs
	  ○ FPPEs for cause
	  ○ Reporting of privileging actions to National Practitioner Data Bank
		• Facility clinical managers include service-specific criteria in OPPEs for LIPs.
		• OPPE results are based on evaluation by another provider with similar training and privileges.
			• Facility clinical managers define criteria in advance for LIPs' FPPEs.
			• Facilities' executive committee of the medical staff document the decision to recommend continuing privileges for LIPs based on OPPE results.
			• Facility clinical managers clearly define and share in advance the expectations, outcomes, and time frames with LIPs for FPPEs for cause.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level
	• Establishment of a VISN Emergency Management Committee
	• Assessment of inventory management programs through a quality control review once per FY
	• Facility-level CHIP indicators:
	  ○ Parent facility
	  ○ Community based outpatient clinic
	  ○ Locked inpatient mental health unit
	  ○ Emergency management
		• None	• A written policy establishes and maintains a VISN-level Comprehensive EOC program.
			• The emergency management committee conducts an annual review of the emergency operations plan, continuity of operations plan, and hazards vulnerability analysis.
			• The emergency management committee conducts, documents, and sends an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to leadership for review and approval.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Medication Management: Controlled Substances Inspections	• VISN quality management officer review of facility quarterly trend reports
	• Facility-level CHIP indicators:
	  ○ Controlled substances coordinator reports
	  ○ Pharmacy operations
	  ○ Controlled substances inspector requirements
	  ○ Controlled substances area inspections
	  ○ Pharmacy inspections
	  ○ Facility review of override reports
		• None	• The QMO reviews VISN facilities' controlled substances inspection quarterly trend reports.

Appendix B: VISN 1 Profile

The table below provides general background information for VISN 1.

Table B.1. Profile for VISN 1
(October 1, 2015, through September 30, 2018)

Profile Element	VISN Data FY 2016[60]	VISN Data FY 2017[61]	VISN Data FY 2018[62]
Total medical care budget in dollars	$2,706,573,294	$2,884,709,963	$3,026,590,354
Number of:			
• Unique patients	260,587	261,478	261,868
• Outpatient visits	3,586,984	3,586,555	3,594,341
• Unique employees[63]	12,214	12,231	12,332
Type and number of operating beds:			
• Community living center	688	700	700
• Domiciliary	194	200	200
• Hospital	801	803	790
• Residential rehabilitation	91	91	91
Average daily census:			
• Community living center	472	483	469
• Domiciliary	137	148	156
• Hospital	549	544	511
• Residential rehabilitation	70	68	67

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

[60] October 1, 2015, through September 30, 2016.
[61] October 1, 2016, through September 30, 2017.
[62] October 1, 2017, through September 30, 2018.
[63] Unique employees involved in direct medical care (cost center 8200).

Appendix C: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 1 (October 1, 2017, through September 30, 2018)

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	VHA	66.9
		VISN 1	74.3
		Augusta, ME	75.3
		Bedford, MA[64]	n/a
		Boston, MA	71.9
		Leeds, MA[65]	n/a
		Manchester, MA[66]	n/a
		Providence, RI	71.2
		West Haven, CT	77.9
		White River Junction, VT	82.4
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.2
		VISN 1	88.6
		Augusta, ME	90.0
		Bedford, MA	n/a
		Boston, MA	86.6
		Leeds, MA	n/a
		Manchester, MA	n/a
		Providence, RI	87.3
		West Haven, CT	91.3
		White River Junction, VT	93.5

[64] The facility had limited or no responses, therefore, the survey questions are not applicable (n/a).

[65] The facility only provides mental health inpatient care, therefore, the survey questions are not applicable (n/a).

[66] The facility does not provide inpatient care, therefore, the survey questions are not applicable (n/a).

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	76.3
		VISN 1	83.4
		Augusta, ME	82.3
		Bedford, MA	84.1
		Boston, MA	84.8
		Leeds, MA	83.3
		Manchester, MA	82.5
		Providence, RI	83.4
		West Haven, CT	84.6
		White River Junction, VT	81.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	76.5
		VISN 1	82.3
		Augusta, ME	84.9
		Bedford, MA	84.9
		Boston, MA	82.0
		Leeds, MA	82.8
		Manchester, MA	77.8
		Providence, RI	79.5
		West Haven, CT	84.3
		White River Junction, VT	79.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)
n/a = Not applicable

Table C.2. Inpatient Survey Results by Gender within VISN 1 (October 1, 2017, through September 30, 2018)

Questions	Scoring	Facility	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**83.6**	**81.4**
		VISN 1	87.3	92.3
		Augusta, ME	89.5	100.0
		Bedford, MA[67]	n/a	n/a
		Boston, MA	85.1	100.0
		Leeds, MA[68]	n/a	n/a
		Manchester, MA[69]	n/a	n/a
		Providence, RI	88.5	55.4
		West Haven, CT	89.6	100.0
		White River Junction, VT	89.2	89.7
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**82.7**	**81.9**
		VISN 1	87.1	87.7
		Augusta, ME	91.2	94.9
		Bedford, MA	n/a	n/a
		Boston, MA	85.1	82.8
		Leeds, MA	n/a	n/a
		Manchester, MA	n/a	n/a
		Providence, RI	87.7	69.8
		West Haven, CT[70]	88.1	—
		White River Junction, VT	89.6	100.0

[67] The facility had limited or no responses, therefore, the survey questions are not applicable (n/a).

[68] The facility only provides mental health inpatient care, therefore, the survey questions are not applicable (n/a).

[69] The facility does not provide inpatient care, therefore, the survey questions are not applicable (n/a).

[70] Although the facility provides inpatient care, data is not available for the limited number of female respondents.

Questions	Scoring	Facility	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The reporting measure is calculated as the percentage of responses in the top category (Definitely yes).	**VHA**	**67.4**	**59.5**
		VISN 1	74.6	66.0
		Augusta, ME	74.6	87.7
		Bedford, MA	n/a	n/a
		Boston, MA	72.2	62.8
		Leeds, MA	n/a	n/a
		Manchester, MA	n/a	n/a
		Providence, RI	72.6	31.5
		West Haven, CT	78.2	67.4
		White River Junction, VT	82.0	89.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 3, 2019)

Table C.3. Patient-Centered Medical Home Survey Results by Gender within VISN 1 (October 1, 2017, through September 30, 2018)

Questions	Scoring	Facility	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**50.2**	**40.3**
		VISN 1	60.6	54.5
		Augusta, ME	61.1	72.0
		Bedford, MA[71]	67.1	—
		Boston, MA	59.9	39.5
		Leeds, MA	56.3	46.0
		Manchester, MA	55.2	67.3
		Providence, RI	61.1	41.5
		West Haven, CT	62.5	48.8
		White River Junction, VT	60.5	69.3
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**58.8**	**49.8**
		VISN 1	68.4	61.7
		Augusta, ME	68.5	79.7
		Bedford, MA	71.6	87.1
		Boston, MA	66.5	72.1
		Leeds, MA	63.4	35.8
		Manchester, MA	65.9	34.0
		Providence, RI	69.4	31.0
		West Haven, CT	69.1	67.8
		White River Junction, VT	73.7	63.3

[71] Data is not available for the limited number of female respondents for Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA).

Questions	Scoring	Facility	Male Average	Female Average
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	**VHA**	**70.1**	**65.7**
		VISN 1	76.2	71.5
		Augusta, ME	73.5	67.3
		Bedford, MA	77.5	82.9
		Boston, MA	75.6	85.9
		Leeds, MA	76.4	73.5
		Manchester, MA	70.9	44.9
		Providence, RI	77.9	78.2
		West Haven, CT	78.3	63.1
		White River Junction, VT	78.9	88.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 3, 2019)

Table C.4. Specialty Care Survey Results by Gender within VISN 1 (October 1, 2017, through September 30, 2018)

Questions	Scoring	Facility	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	VHA	47.6	43.2
		VISN 1	56.6	57.5
		Augusta, ME	59.8	85.4
		Bedford, MA	47.6	70.3
		Boston, MA	60.7	33.6
		Leeds, MA	58.3	82.8
		Manchester, MA	46.6	25.3
		Providence, RI	52.3	25.3
		West Haven, CT	55.5	54.3
		White River Junction, VT	64.1	75.1
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	VHA	55.2	50.7
		VISN 1	64.4	57.5
		Augusta, ME	64.8	50.2
		Bedford, MA	67.5	82.3
		Boston, MA	68.0	51.5
		Leeds, MA	60.5	80.7
		Manchester, MA	65.4	55.2
		Providence, RI	59.4	46.4
		West Haven, CT	63.4	56.5
		White River Junction, VT	64.2	63.7
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	VHA	68.7	65.5
		VISN 1	73.7	68.9
		Augusta, ME	75.4	82.0
		Bedford, MA	71.3	70.8
		Boston, MA	74.0	78.9
		Leeds, MA	75.7	67.9
		Manchester, MA	53.4	36.5
		Providence, RI	68.8	58.5
		West Haven, CT	72.9	49.1
		White River Junction, VT	75.8	88.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 3, 2019)

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection Program Review of the VA Maine Healthcare System, Augusta, Maine, Report No. 18-01152-14, November 28, 2018	June 2018	0	7	n/a	4
Clinical Assessment Program Review of the White River Junction VA Medical Center, White River Junction, Vermont, Report No. 16-00556-244, June 20, 2017	December 2016	0	24	n/a	0
Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts, Report No. 15-00598-446, July 22, 2015	May 2015	0	13	n/a	0
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts, Report No. 15-00138-392, July 13, 2015	May 2015	0	7	n/a	0
Comprehensive Healthcare Inspection Program Review of the VA Boston Healthcare System, Massachusetts, Report No. 17-05570-06, October 23, 2018	April 2018	0	7	n/a	3
Review of Delays in Clinical Consult Processing at VA Boston Healthcare System, Massachusetts, Report No. 17-05504-107, April 11, 2019	June 2018	0	0	n/a	n/a
Combined Assessment Program Review of the Manchester VA Medical Center, Manchester, New Hampshire, Report No. 15-00620-548, September 30, 2015	August 2015	0	8	n/a	0
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Manchester VA Medical Center, Manchester, New Hampshire, Report No. 15-00171-533, September 30, 2015	August 2015	0	1	n/a	0
Healthcare Inspection – Inconsistent Transfer Procedures for Urgent Care Clinic Patients with Stroke	June 2015	0	3	n/a	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Symptoms, Manchester VA Medical Center, Manchester, New Hampshire, Report No. 15-03288-362, September 7, 2017	February 2016				
Combined Assessment Program Review of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts, Report No. 14-04228-144, March 4, 2015	December 2014	0	13	n/a	0
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts, Report No. 14-04396-142, March 4, 2015	December 2014	0	6	n/a	0
Administrative Closure – Alleged Environment of Care Deficiencies in the Post-Traumatic Stress Disorder Unit, VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts, March 18, 2015	March 2014	0	0	n/a	n/a
Comprehensive Healthcare Inspection Program Review of the Providence VA Medical Center, Providence, Rhode Island, Report No. 17-01761-129, March 21, 2018	August 2017	0	12	n/a	0
Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, Connecticut, Report No. 16-00116-323, June 23, 2016	March 2016	0	9	n/a	0
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Connecticut Healthcare System, West Haven, Connecticut, Report No. 16-00027-318, June 10, 2016	March 2016	0	5	n/a	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Healthcare Inspection – Alleged Failure in Patient Notification of Test Results, VA Connecticut Healthcare System, West Haven, Connecticut, Report No. 17-02678-107, February 27, 2018[72]	n/a	0	1	n/a	0

Sources: Inspection/survey results verified with the QMO on June 5, 2019.
n/a = Not applicable

[72] The OIG inspection team did not conduct a site visit.

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[73]

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

[73] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PC routine care appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

Measure	Definition	Desired Direction
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty care wait time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix F: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[74]

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

[74] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated May 21, 2019). https://secure reports2.vssc.med.va.gov/ (The website was accessed on July 18, 2019).

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 9, 2019

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

Subj: Comprehensive Healthcare Inspection of the VA New England Healthcare System, Bedford, MA

To: Director, Office of Healthcare Inspections (54 CH05)

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the VA New England Healthcare System, Bedford, MA. I appreciate the Office of Inspector General's oversight and the extensive work done as part of this review. We acknowledge there are improvements to be made and we are committed to timely implementation of Office of Inspector General recommendations.
2. I have reviewed the action plans and projected completion dates. I concur with the plan and have complete confidence that the plans will be effective.

(Original signed by:)

Ryan Lilly, MPA
Director, VA New England Healthcare System (VISN 1)

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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