DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire

CHIP REPORT | REPORT #21-00262-247 | SEPTEMBER 15, 2021

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Figure 1. *Manchester VA Medical Center in New Hampshire.*
Source: https://vaww.va.gov/directory/guide (*accessed January 26, 2021*).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the outpatient setting of the Manchester VA Medical Center and four outpatient clinics in New Hampshire. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

The OIG conducted an unannounced virtual review of the Manchester VA Medical Center during the week of February 1, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this

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

[2] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the Manchester VA Medical Center because staff did not administer remdesivir during the review period.

report may help this medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual review, the medical center's leadership team consisted of the Medical Center Director, acting Chief of Staff, Associate Director for Patient Care Services, and Associate Director. Organizational communications and accountability were managed through a committee reporting structure, with the Executive Council having oversight of several working groups. Leaders monitored patient safety and care through the Quality, Safety and Value Council, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's permanently assigned leaders had worked as a team in their current roles for less than a month but had been working together in various leadership roles for over two years. The Associate Director for Patient Care Services, assigned in May 2020, was the most tenured leader. The Medical Center Director and Associate Director received permanent appointments in June 2020 and January 2021, respectively, after serving in an acting capacity. The acting Chief of Staff assumed the role in August 2020 when the former Chief of Staff retired.

During an interview with the OIG, the Director indicated that the fiscal year 2020 budget increase of approximately 26 percent from the previous year helped expand pain management services, hire additional primary care providers, and assign more social workers in the community-based outpatient clinics.

Selected employee satisfaction survey results indicated that the Director had opportunities to improve servant leader behaviors and reduce staff feelings of moral distress at work.[3] The selected outpatient experience survey scores generally reflected higher overall satisfaction with care than the VHA average. Although female veterans generally reported getting appointments

[3] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing." The Servant Leader Index is a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns.

when needed, the OIG found that leaders have opportunities to improve female veterans' experiences in the outpatient settings.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[4]

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[5] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[6]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific medical center and Community Living Center SAIL measures.[7] In individual interviews, the executive leadership team members discussed actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The OIG found general compliance with quality, safety, and value requirements, including the Quality, Safety and Value Council; the Systems Redesign and Improvement Program; and protected peer reviews. However, the OIG noted inconsistent meeting attendance by Surgical Work Group members.

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

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

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

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

Care Coordination

The medical center met expectations for an inter-facility transfer policy. However, the OIG identified deficiencies with monitoring and evaluation of inter-facility transfers, completion of required elements of the VA *Inter-Facility Transfer Form*, transmission of patients' active medication lists and advance directives to receiving facilities, and communication between nurses at sending and receiving facilities.[8]

High-Risk Processes

The medical center met many of the requirements for the management of disruptive and violent behavior. However, the OIG found deficiencies with Disruptive Behavior Committee meeting attendance and staff training.

Conclusion

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

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

Comments

The Veterans Integrated Service Network Director and acting Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 54–55, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendation 1 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
for Healthcare Inspections

Contents

Purpose and Scope

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

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

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review, paused physical inspection steps (especially those involved in the environment of care-focused review topic), and initiated a COVID-19 pandemic readiness and response evaluation.

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

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[5]
3. Quality, safety, and value (QSV)
4. Registered nurse credentialing

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

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

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

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

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

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

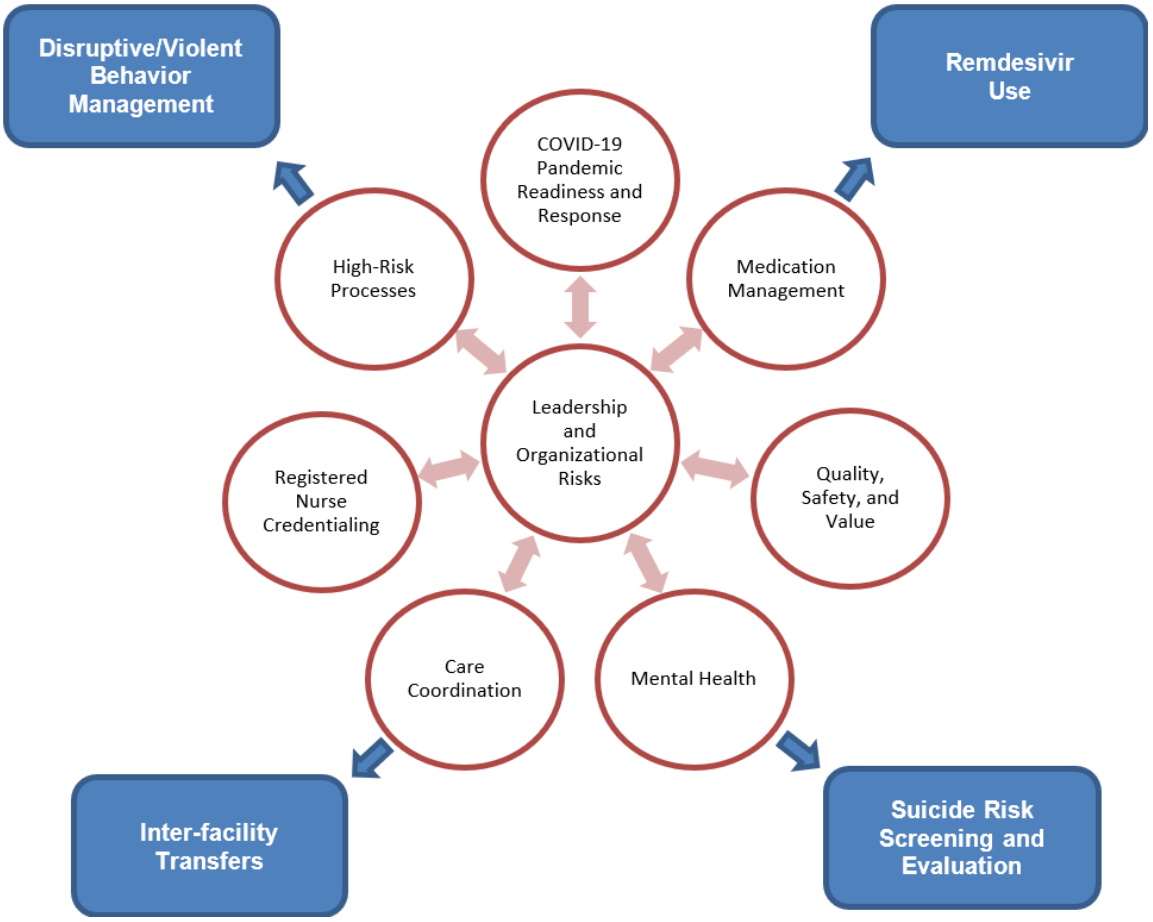


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

[6] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the Manchester VA Medical Center because staff did not administer remdesivir during the review period.

Methodology

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

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality and clinical functions, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[7] The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from June 8, 2019, through February 5, 2021, the last day of the unannounced multiday evaluation.[8] During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

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

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

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

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

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

[8] The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in February 2021.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect a healthcare system's ability to provide care in the clinical focus areas.[10] To assess this medical center's risks, the OIG considered several indicators:

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

Executive Leadership Position Stability and Engagement

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

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

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

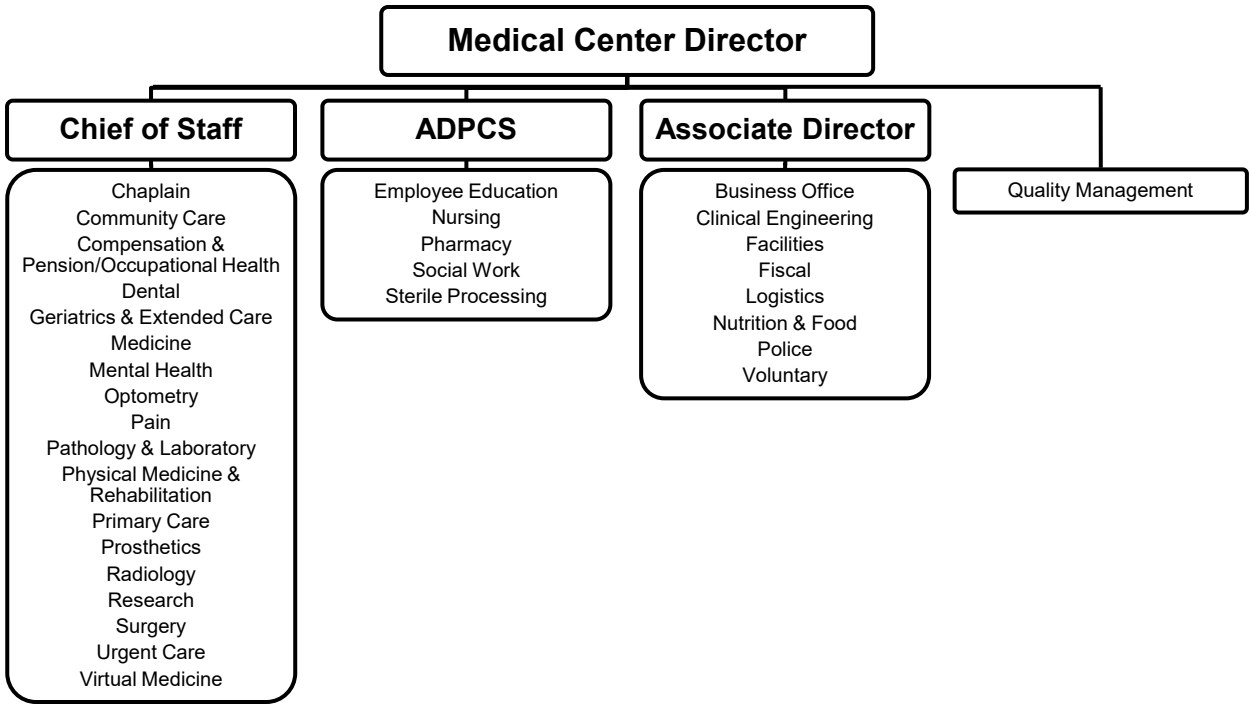


Figure 3. *Medical center organizational chart.*
Source: Manchester VA Medical Center (received February 1, 2021).

At the time of the OIG inspection, the permanently assigned members of the executive team had worked together in their current roles for less than a month. However, the leaders had collaborated in past leadership roles for over two years. The ADPCS, assigned in May 2020, was the most tenured leader and had served as a chief nurse at the facility for over three years. The Director and Associate Director received permanent appointments after serving in an acting capacity. The Director previously served as the facility's Associate Director since October 2016, and the current Associate Director held a service chief role for almost two and half years prior to appointment as the Associate Director. The acting Chief of Staff assumed the role when the former Chief of Staff retired in August 2020 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	October 13, 2019 (acting); June 7, 2020 (permanent)
Chief of Staff	August 9, 2020 (acting)
Associate Director for Patient Care Services	May 10, 2020
Associate Director	March 1, 2020 (acting); January 17, 2021 (permanent)

Source: Manchester VA Medical Center Human Resources Senior Strategic Business Partner (received February 1 and May 3, 2021).

To help assess the medical center executive leaders' engagement, the OIG interviewed the Director, acting Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures and CLC SAIL measures. In individual interviews, the executive leadership team members were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences. These are discussed in greater detail below.

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

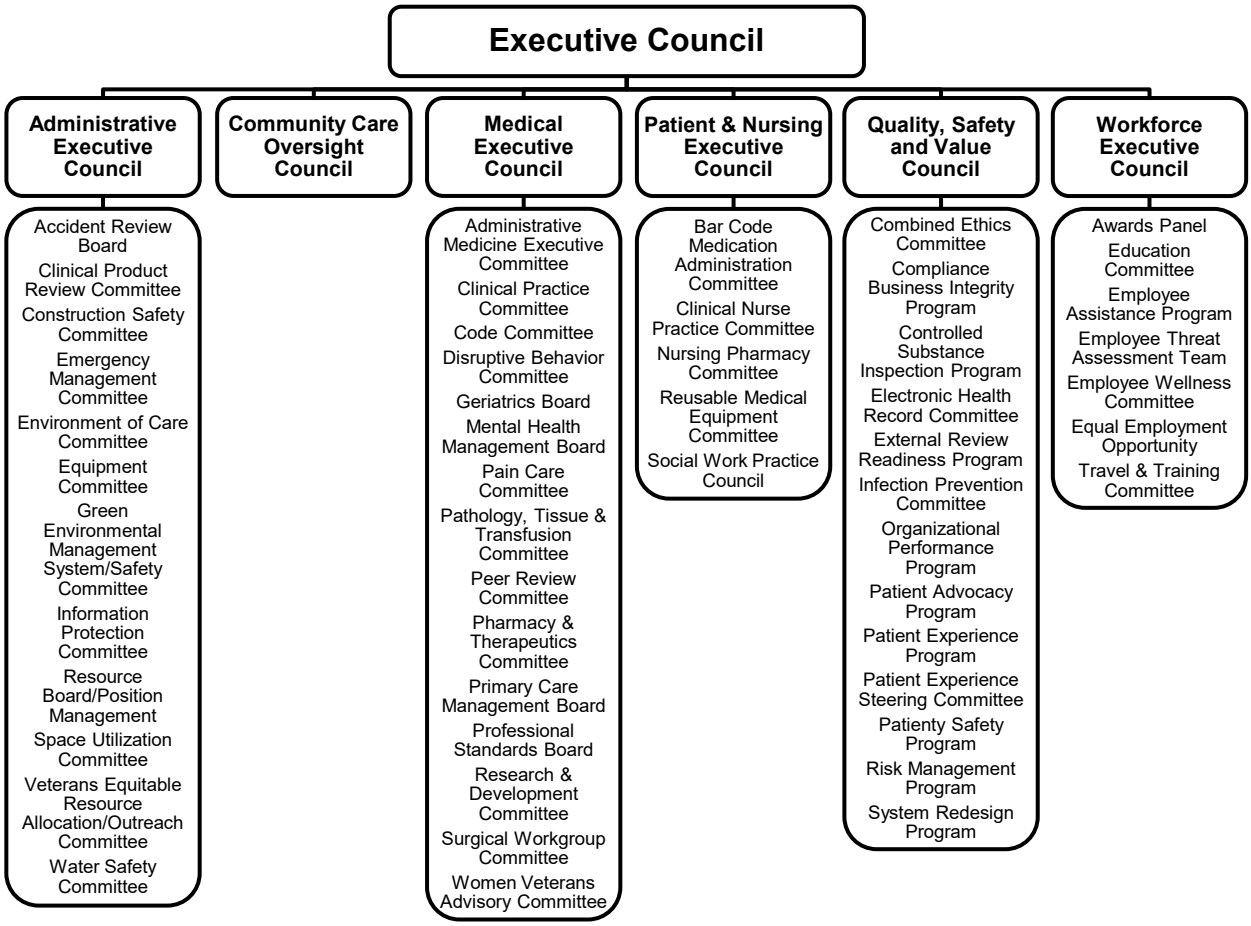


Figure 4. *Medical center committee reporting structure.*
Source: Manchester VA Medical Center (received February 1, 2021).

Budget and Operations

The medical center's FY 2020 annual medical care budget of $289,858,207 increased by approximately 26 percent compared to the previous year's budget of $230,351,174.[12] When asked about the effect of this change on the medical center's operations, the Director indicated that this helped the medical center expand pain management services, hire additional primary care providers, and assign more social workers in the community-based outpatient clinics.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[13] Under the authority

[12] VHA Support Service Center.

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

of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[14] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[15]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[16] The executive leaders confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection. The executive team spoke about strategies implemented to address clinical and nonclinical occupational shortages, which included conducting salary surveys, providing bonuses, approving full-time telework for select positions (medical record technicians), and establishing a residency program for mental health nurse practitioners. Leaders reportedly filled key leadership positions in the police department but verbalized ongoing recruitment challenges for police officers. Despite the strategies implemented, the executive team explained that the positions identified as occupational shortages present ongoing retention and recruitment challenges.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Nursing Assistant	1. Medical Supply Aide and Technician
2. Psychiatrist	2. Boiler Plant Operator
3. Nurse Practitioner – Mental Health/Substance Use Disorder	3. Police
4. Pain Management/Anesthesiologist	4. Medical Records Technician
5. Registered Nurse (RN) Staff – Outpatient Mental Health	5. –*

Source: VA OIG.

**The medical center reported four nonclinical occupation shortages.*

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

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

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

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

times in response to VA leaders' inquiries on VA culture and organizational health.[17] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[18] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center average for the selected survey leadership questions was similar to or lower than the VHA average.[19] The Director's score for the servant leadership index composite was markedly lower than VHA and medical center averages. However, the acting Chief of Staff, ADPCS, and Associate Director scores were consistently higher than those for VHA and the medical center.[20] The Director expressed a commitment to servant leadership and attributed the lower score to a combination of a small number of direct-report survey respondents and holding employees accountable around the time VHA administered the survey.

[17] "AES Survey History," VA Workforce Surveys Portal, VHA Support Service Center, accessed May 3, 2021, http://aes.vssc.med.va.gov/Documents/04_AES_History_Concepts.pdf. (This is an internal website not publicly accessible.)

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

[19] 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.

[20] The 2020 All Employee Survey results are not fully reflective of employee satisfaction with the current ADPCS, who assumed the role approximately four months prior to the survey being administered. The results are also not fully reflective of the acting Chief of Staff, who assumed the role during the review period.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	72.7	57.2	78.0	78.3	83.9
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.4	3.3	3.8	3.7	3.8
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.6	3.4	3.8	3.8	4.2
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.6	3.1	3.8	3.9	4.2

Source: VA All Employee Survey (accessed January 4, 2021).

**The Servant Leader Index is a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns.*

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[21] The medical center average for the selected survey questions was similar to the VHA average. However, opportunities appeared to exist for the Director to take measures to reduce employees' feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing). The Director attributed this score to holding employees accountable and having candid discussions with them around the time VHA administered the survey.

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.0	3.9	3.8	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)	3.8	3.7	3.2	4.0	3.4	3.9

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.4	2.0	1.7	1.6	1.2

Source: VA All Employee Survey (accessed January 4, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment." To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[22]

To demonstrate commitment to a culture of safety, the Director reported implementing strategies from VA's "Stand Up to Stop Harassment Now!" campaign and communicating the medical center's expectation of zero tolerance for discrimination and harassment during new employee orientation.[23] Additionally, the medical center disseminates a consistent message of zero tolerance through a diversity and inclusion newsletter.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The medical center and executive leadership team averages for the selected survey questions were generally similar to or higher than the VHA average. Leaders appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.

[22] "Stand Up to Stop Harassment Now!" Department of Veterans Affairs, accessed December 8, 2020, https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/. Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

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

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.9	3.8	3.6	4.1	3.8	4.2
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.1	4.2	4.3	4.2	4.3	4.7
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	3.5	4.0	3.9	4.2

Source: VA All Employee Survey (accessed January 4, 2021).

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to two selected survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the Manchester VA Medical Center.[24]

For this medical center, the outpatient satisfaction survey results reflected higher care ratings than the VHA average.

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

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	89.0
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	90.2

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[25] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender for Patient-Centered Medical Home and Specialty Care surveys (see tables 7–8). For female veterans, the outpatient survey results were generally less favorable than the corresponding VHA averages. The scores suggest that although female veterans may get appointments when needed, leaders have opportunities to improve experiences for female veterans in patient-centered medical home and specialty care settings. Leaders attributed the lower-than-average female veteran scores to the small survey sample size, the women's health clinic's inconvenient location and small size, and absence of women-specific health care services (such as mammograms) and childcare services. At the time of this virtual inspection, leaders reported initiating plans to construct a new women's health clinic with a separate entrance and offering a women's health mini-residency program for providers. Additionally, the Associate Director spoke about the medical center's new women-specific classes on mindfulness, yoga, and tai chi.

[25] "Veteran Population," Table 1L: VetPop2018 Living Veterans by Age Group, Gender, 2018-2048, National Center for Veterans Analysis and Statistics, accessed November 30, 2020, https://www.va.gov/vetdata/Veteran_Population.asp.

Table 7. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	55.7	73.3
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).	59.5	53.0	64.6	50.0
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	70.9	49.0

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

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

The medical center averages are based on 248–892 male and 18–47 female respondents, depending on the question.

Table 8. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	47.2	76.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	65.8	41.7
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).	75.1	72.2	80.2	62.3

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

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

The medical center averages are based on 282–881 male and 20–55 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[26] Table 9 summarizes the relevant medical center inspection most recently performed by the OIG. At the time of the virtual review, the medical center had closed all but five recommendations since the

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

last inspection in June 2019. The acting Chief of Quality Management reported actively addressing the open recommendations.

Additionally, the OIG noted the medical center's most recent accreditation by the Commission on Accreditation of Rehabilitation Facilities. The medical center had not undergone a College of American Pathologists accreditation since the last OIG inspection.[27]

Table 9. Office of Inspector General Inspection

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the Manchester VA Medical Center, New Hampshire*, Report No. 19-00040-10, November 25, 2019)	June 2019	17	5*

Source: OIG.

**As of September 2021, two recommendations remained open.*

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

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

[27] VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment "is supported through a system-wide, long-term joint collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs." "About the College of American Pathologists," College of American Pathologists, accessed February 20, 2019, https://www.cap.org/about-the-cap. According to the College of American Pathologists, for 75 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." Additionally, as stated in VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

Table 10 lists the reported patient safety events from June 8, 2019 (the prior OIG CHIP site visit), through February 1, 2021.[28]

Table 10. Summary of Selected Organizational Risk Factors (June 8, 2019, through February 1, 2021)

Factor	Number of Occurrences
Sentinel Events	1
Institutional Disclosures	1
Large-Scale Disclosures	0

Source: Manchester VA Medical Center's Performance Improvement Coordinator (received February 2, 2021).

The Director spoke knowledgeably about serious adverse event reporting processes, including discussing all events at the Director's daily morning conference and during huddles with the Patient Safety Manager. Sentinel event determinations reportedly were made collaboratively through discussion with risk management and the VISN Quality Management Officer and discussions included whether institutional disclosures were warranted.

Veterans Health Administration Performance Data for the Medical Center

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[29] Despite noted limitations for identifying all areas

[28] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The Manchester VA Medical Center is a low complexity (3) medical center as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

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

of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[30]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the medical center's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of emergency department (ED) throughput, mental health (MH) continuity (of) care, and rating (of) specialty care (SC) provider). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, patient-centered medical home (PCMH) care coordination, rating (of) primary care (PC) provider, and MH experience (exp) of care).[31]

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

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

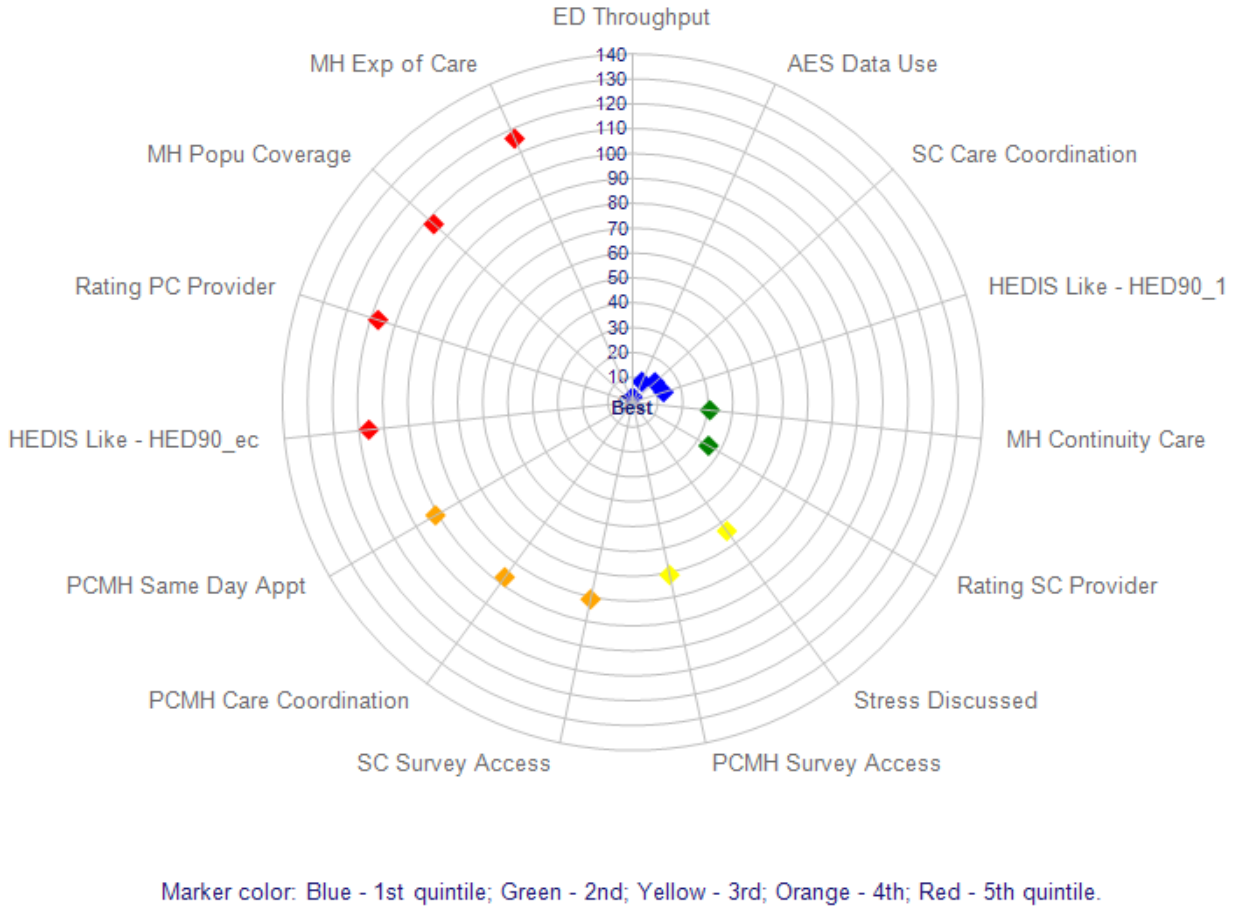


Figure 5. *Medical center quality of care and efficiency metric rankings for fiscal year 2020 quarter 3 (as of June 30, 2020).*

Source: VHA Support Service Center.

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

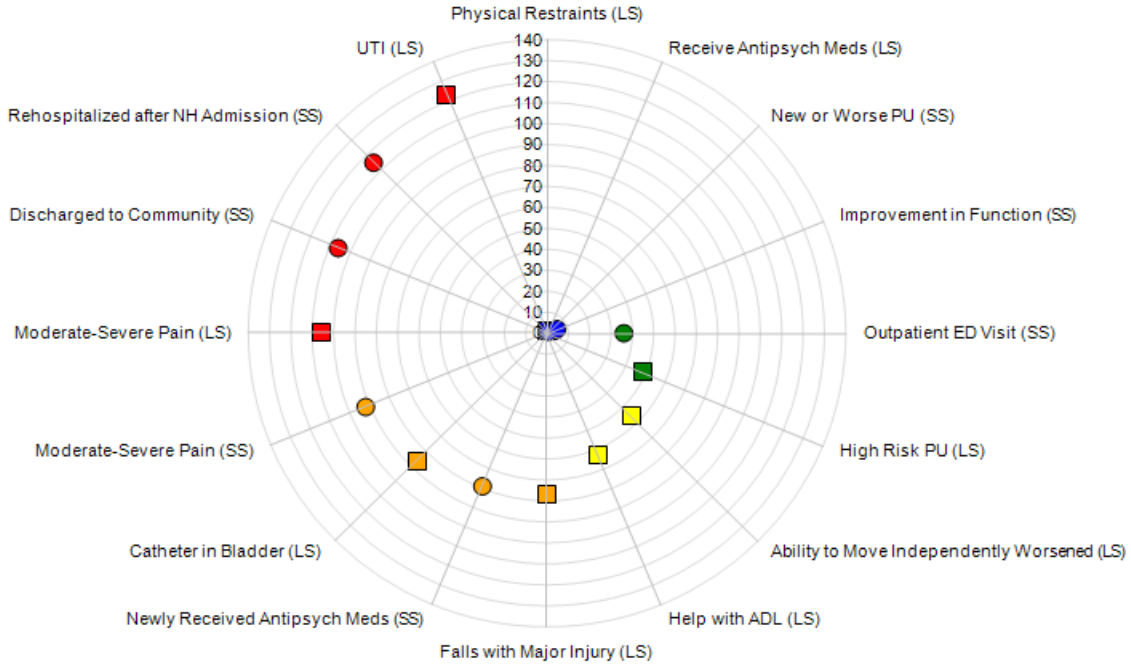
Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[32] The model "leverages much of the same data" used in the Centers for Medicare &

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[33]

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the medical center's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of physical restraints–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and outpatient emergency department (ED) visit (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, moderate-severe pain (SS), rehospitalized after nursing home (NH) admission (SS), and urinary tract infections (UTI) (LS)).[34]



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

Figure 6. *Manchester CLC quality measure rankings (as of June 30, 2020).*

LS = Long-Stay Measure. *SS = Short-Stay Measure.*

Source: VHA Support Service Center.

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

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

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

Leadership and Organizational Risks Findings and Recommendations

At the time of the site visit, the executive leadership team had a vacancy in one of four key positions. The remaining three positions had been filled for less than one year. The permanently assigned leaders had worked as a team in their current roles for less than a month but had been working together in various leadership roles for over two years.

A budget increase of approximately 26 percent in FY 2020 helped the medical center expand pain management services, hire additional primary care providers, and assign more social workers in the community-based outpatient clinics. The executive leaders were able to discuss strategies to address clinical and nonclinical occupational shortages.

Selected employee survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected and discrimination was not tolerated. However, the OIG noted opportunities to improve servant leadership behaviors and reduce staff feelings of moral distress at work. Patient experience survey data identified opportunities to improve female veterans' experiences in the outpatient settings. Leaders reported efforts to address female veterans' concerns by initiating plans to construct a new women's health clinic with a separate entrance and offering a women's health mini-residency program for providers.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. In addition, the executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL measures and should continue to take actions to improve performance.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[35] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[36]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[37] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[38]

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

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

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

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

[35] "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed December 8, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

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

[37] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

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

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.[39] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[40] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[41]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center's committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG also assessed the medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[42] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[43] The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator
- Tracking of facility-level performance improvement capability and projects
- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group
- Staff education on performance improvement principles and techniques

[39] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[40] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[41] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence.*
[42] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.
[43] VHA Directive 1026.01.

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[44] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[45] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[46] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[47]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[48]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[49] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities;

[44] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. § 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

[45] VHA Directive 1190.

[46] VHA Directive 1190.

[47] VHA Directive 1190.

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

[49] "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, https://vaww.nso.med.va.gov/apps/VASQIP/Pages/Default.aspx. (This is an internal VA website not publicly accessible.)

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[50] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[51]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[52]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight, the Systems Redesign and Improvement Program, and protected peer reviews. However, the OIG noted inconsistent meeting attendance by Surgical Work Group members.

VHA requires medical facilities with surgery programs to have a surgical work group with membership that includes the Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and the Operating Room Nurse Manager.[53] The OIG reviewed available Surgical Work Group meeting minutes from January 1 through December 31, 2020, and found that three of the four required members—the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager—did not consistently attend meetings.[54] Lack of executive and surgical leaders' involvement may have resulted in the review and analysis of surgery program data without the perspectives of key staff. The Chief of Surgery and Chief of Staff cited competing priorities, lack of a dedicated Surgical Quality Nurse, and unawareness of attendance requirements for the Operating Room Nurse Manager as reasons for noncompliance.[55]

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

[51] VHA Directive 1102.01(1), *National Surgery Office,* April 24, 2019, amended May 22, 2019.

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

[53] VHA Directive 1102.01(1).

[54] The Surgical Work Group did not meet in March 2020 because elective surgical cases were suspended due to the COVID-19 pandemic; therefore, there were 11 required meetings during the review period.

[55] At the time of the virtual review, the Surgical Quality Nurse's position was shared between the Manchester and White River Junction VA Medical Centers.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that required members consistently attend Surgical Work Group meetings.[56]

Medical center response: Medical center concurred.

Target date for completion: Completed

Medical center response: The Medical Center Director reviewed and found no additional reasons for noncompliance. On February 25, 2021, the Chief of Staff [COS], and the Chief of Surgical Services reviewed VHA Directive 1102.01(1), National Surgery Office [SWG], April 24, 2019, during the meeting to ensure The Surgical Workgroup understands the attendance requirements. The requirements were noted in the minutes, and discussion was held regarding the need to have key members attend the Surgical Workgroup or send appropriate designee. The key members are as follows, Chief of Staff, Chief, Surgical Services, Nurse Manager OR [Operating Room], and Surgical Quality Nurse.

Quality Management reviewed the Surgical Work Group minutes from February 2021 - August 11, 2021, the minutes demonstrate that the key members or designees have had 100% attendance since the February 25, 2021 meeting.

The Chief of Surgical services and Acting COS will report the SWG minutes quarterly to the Medical Executive Committee. The Surgical Workgroup will continue to monitor for key attendees and any non-compliance will be reported to the SWG Chairperson and COS for follow up.

We request closure based on evidence provided to OIG prior to publication.

[56] The OIG reviewed evidence sufficient to demonstrate that medical center staff had completed improvement actions, and therefore, closed the recommendation before publication of the report.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[57] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[58]

VA requires all RNs to hold at least one active, unencumbered license.[59] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[60] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[61] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[62]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 36 RNs hired between January 1, 2020, and January 3, 2021. The OIG determined whether

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

The OIG also reviewed credentialing files for 30 of the 36 RNs to determine whether medical center staff completed primary source verification prior to the appointment.

[57] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

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

[59] VHA Directive 2012-030. "Definition of *Unencumbered license,"* Law Insider, accessed December 3, 2020, https://www.lawinsider.com/dictionary/unencumbered-license. An unencumbered license is "a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action."

[60] 38 U.S.C. § 7402.

[61] VHA Directive 2012-030.

[62] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[63] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[64] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[65]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[66] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[67] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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[63] "Preventing Suicide," Centers for Disease Control and Prevention, accessed December 9, 2020, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

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

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

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

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

- the electronic health records of 43 randomly selected patients who were seen in the emergency department/urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[68]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients."[69] Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[70]

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

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

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 49 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The medical center complied with the requirement for a written inter-facility transfer policy. The OIG noted deficiencies with monitoring and evaluation of inter-facility transfers, completion of required elements of the *Inter-Facility Transfer Form*, transmission of patients' active medication lists and advance directives to receiving facilities, and communication between nurses at sending and receiving facilities.

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

[69] VHA Directive 1094.

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

VHA requires the Chief of Staff to ensure that "all transfers are monitored and evaluated as part of VHA's Quality Management Program."[71] The acting Chief of Quality Management reported that there was insufficient monitoring and evaluation of inter-facility transfers. This could inhibit the medical center's ongoing performance improvement activities. The Chief of Urgent Care reported being unaware that the transfer process needed to be monitored and evaluated and believing that monitoring community care patients post-transfer met the requirement.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that transfers are monitored and evaluated as part of Veterans Health Administration's Quality Management Program.

Medical center concurred.

Target date for completion: March 1, 2022

Medical center response: The Chief of Staff reviewed and found no additional reasons for noncompliance. The Performance Improvement Coordinator QM [Quality Management] reviews 100% of all transfers from the facility Urgent Care to ensure compliance with the Inter-facility Directive, this process started June 1, 2021. This process will stay in place until 90% compliance is sustained for six consecutive months. The results from the reviews will be reported to the Urgent Care Monthly Leadership meeting and will be reported out at the QSVC [Quality, Safety and Value Council] monthly as a standing agenda item until 90% compliance is met and noted in minutes starting in September 2021.

Moving forward, monthly audits will remain in place to monitor full compliance of the inter-facility transfer directive. Number of audits will be determined by utilizing the Joint Commission sampling size recommendations.

VHA requires the Chief of Staff to ensure that providers identify the receiving providers on the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note.[72] The OIG estimated that providers did not identify the receiving provider for 43 percent of transfers and instead notified and identified the RN at the receiving facility.[73] This practice is inconsistent with VA policy and could have resulted in the unsafe transfer of patients. The Chief of Urgent Care stated that providers follow community facilities' policies, which stipulate that nurses, as designees, accept transfer patients in lieu of a provider.

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

[72] VHA Directive 1094.

[73] The OIG estimated that 95 percent of the time, the true compliance rate is between 43.8 and 70.8 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that transferring providers identify the receiving provider on the VA *Inter-Facility Transfer Form* or facility-defined equivalent note.

Medical center concurred.

Target date for completion: March 1, 2022

Medical center response: The Chief of Staff reviewed and found no additional reasons for noncompliance. VAMC [VA Medical Center] Manchester Quality Management began working with Urgent Care leadership on processes to become compliant with the directive for interfacility transfers starting in July 2021. Urgent Care leadership is aware of the requirement that an accepting provider or designee must receive report from the transferring VAMC and that the name of the accepting provider is notated. At many of the local hospitals, it is common practice for the charge nurse to accept the patient. This is an internal policy for community facilities.

Along with the work being done internally, there has been a workgroup comprised of multiple disciplines and inclusive of every VISN 1 medical center. The work was divided into a VISN SOP for the process steps and a VISN documentation template in Computerized Patient Record System (CPRS). The template and the Standard Operating Procedure (SOP) FINAL DRAFT are complete, but both are pending approval from Leadership prior to their release. The process needs to be reviewed through the VISN to include QSVC and then sent for review and approval at VISN Executive Leadership Council on September 1, 2021. QM will continue to review 100% of all transfers from the facility Urgent Care to ensure compliance with the Inter-facility Directive, this process started June 1, 2021. This process will stay in place until 90% compliance is sustained for six consecutive months. The results from the reviews will be reported to the Urgent Care Monthly Leadership meeting, and will be reported out at the QSVC monthly as a standing agenda item until 90% compliance is met and noted in minutes starting in September 2021.

Moving forward, monthly audits will remain in place to monitor full compliance of the inter-facility transfer directive. Number of audits will be determined by utilizing the Joint Commission sampling size recommendations.

VHA requires that the Chief of Staff ensures "all pertinent medical records available, including an active patient medication list and any medications given to the patient prior to transfer [be sent] with the patient, including documentation of the patient's advance directive made prior to transfer, if any."[74] The OIG estimated that 49 percent of electronic health records lacked

[74] VHA Directive 1094.

evidence that medical center staff sent an active medication list to the receiving facility.[75] Additionally, the OIG found that all 15 applicable records lacked evidence that staff provided a copy of the advance directive to the receiving facility. These deficiencies could have resulted in the receiving facility's incorrect treatment decisions that may have compromised patient safety. The Chief of Urgent Care and acting Urgent Care Nurse Manager reported that staff sent the required documents to the receiving facility but were unaware of the documentation requirement. Due to the low number of applicable transfers, the OIG made no recommendation related to transmission of the advance directive.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that staff send the patient's active medication list to the receiving facility during the inter-facility transfer.

Medical center concurred.

Target date for completion: February 1, 2022

Medical center response: The Chief of Staff reviewed and found no additional reasons for noncompliance. In speaking with the Urgent Care Nurse Manager, it was determined that a transfer packet of information is always sent with the Emergency Management Service team. This transfer packet includes an active medication list in the triage note. The deficiency was in the lack of documentation that a transfer packet was sent with the patient and what the contents included. The UC [Urgent Care] team will work with the Clinical Application Coordinators to have this added to their standard note.

QM will continue to review 100% of all transfers from the facility Urgent Care to ensure compliance with the Inter-facility Directive, this process started June 1, 2021. This process will stay in place until 90% compliance is sustained for six consecutive months. The results from the reviews will be reported to the Urgent Care Monthly Leadership meeting, and will be reported out at the QSVC monthly as a standing agenda item until 90% compliance is met and noted in minutes starting in September 2021.

Moving forward, monthly audits will remain in place to monitor full compliance of the inter-facility transfer directive. Number of audits will be determined by utilizing the Joint Commission sampling size recommendations.

[75] The OIG estimated that 95 percent of the time, the true compliance rate is between 36.7 and 64.6 percent, which is statistically significantly below the 90 percent benchmark.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at the sending and receiving facilities.[76] The OIG estimated that 22 percent of electronic health records reviewed lacked evidence of nurse-to-nurse communication between the sending and receiving facilities.[77] This could have resulted in nurses at the receiving facility having insufficient information to care for patients. The acting Urgent Care Nurse Manager attributed the noncompliance to competing patient care priorities and indicated that nurse-to-nurse communication did not occur if the transferring physician provided pertinent clinical information to nurses at the receiving facility.

Recommendation 5

5. The Associate Director of Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures nurse-to-nurse communication occurs between the sending and receiving facility.

[76] VHA Directive 1094.

[77] The OIG estimated that 95 percent of the time, the true compliance rate is between 65.3 and 88.0 percent, which is statistically significantly below the 90 percent benchmark.

Medical center concurred.

Target date for completion: December 1, 2021

Medical center response: The Associate Director of Patient Care Services reviewed and found no additional reasons for non-compliance. In the local community, it is standard practice for the VA provider to give report to the charge nurse at the accepting facility. Accepting Licensed Independent Practitioners (LIP) are rarely available for provider to provider hand-off. Because the transferring provider gives report to the charge nurse, the accepting facility will often refuse a nurse to nurse handoff due to redundancy. The VA Urgent Care nurses have been educated on the importance of completing this nurse to nurse handoff and the need for documenting the attempt, whether it is successful or not. There is a template located in CPRS that will be utilized to meet the nurse-to-nurse handoff criteria.

QM will continue to review 100% of all transfers from the facility Urgent Care to ensure compliance with the Inter-facility Directive, this process started June 1, 2021. This process will stay in place until 90% compliance is sustained for six consecutive months. The results from the reviews will be reported to the Urgent Care Monthly Leadership meeting and will be reported out at the QSVC monthly as a standing agenda item until 90% compliance is met and noted in minutes starting in September 2021.

Moving forward, monthly audits will remain in place to monitor full compliance of the inter-facility transfer directive. Number of audits will be determined by utilizing the Joint Commission sampling size recommendations.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[78] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[79] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[80]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[81]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[82]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[83]

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

[79] VHA Directive 2012-026.

[80] VHA Directive 2012-026. An employee threat assessment team is "a facility-level, interdisciplinary team whose primary charge is using evidence-based and data-driven practices for addressing the risk of violence posed by employee-generated behavior(s), that are disruptive or that undermine a culture of safety."

[81] VHA Directive 2012-026. VHA defines a disruptive behavior committee or board as "a facility-level, interdisciplinary committee whose primary charge is using evidence-based and data-driven practices for preventing, identifying, assessing, managing, reducing, and tracking patient-generated disruptive behavior."

[82] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018. VA requires each medical facility's disruptive behavior committee "to use the Disruptive Behavior Reporting System (DBRS) to document a decision to implement an Order of Behavioral Restriction (OBR) and to document notification of a patient when an OBR is issued."

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[84] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[85] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The medical center addressed many of the requirements for the management of disruptive and violent behavior. However, the OIG noted deficiencies with Disruptive Behavior Committee meeting attendance and staff training.

VHA requires that the Chief of Staff and Nurse Executive (ADPCS) are responsible for establishing a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; a patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the Union Safety Committee.[86]

The OIG found that from January through December 2020, representatives from administrative support and the Prevention and Management of Disruptive Behavior Program did not attend 7 of 12 (58 percent) and 2 of 12 (17 percent) meetings, respectively. This could have resulted in a lack of knowledge and expertise when assessing patients' disruptive behavior. The Chief of Mental Health reported that administrative support staff were unable to attend meetings due to staff vacancies. The Talent Management System Domain Manager attributed the former Prevention and Management of Disruptive Behavior Program representative's lack of attendance to leave and competing priorities.

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

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

[86] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

Recommendation 6

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

Medical center concurred.

Target date for completion: March 1, 2022

Medical center response: The Chief of Staff and Associate Director of Patient Care Services reviewed and found no additional reasons for non-compliance. Manchester VAMC is in the process of assigning a new DBC [Disruptive Behavior Committee] Chairperson as the current chair assumed a new position in July 2021. In July 2021, Manchester VAMC held a planning meeting with the medical center Workplace Violence Prevention lead and VACO [Veterans Affairs Central Office] program manager to discuss changes in both DBC and Employee Threat Assessment Team membership. The new Chairperson will review the requirements with the committee to ensure that the required members of the DBC know of their need to attend the committee or send an appropriate delegate. Attendance will be monitored at the committee meeting and any required attendees who did not attend or send a delegate will be referred to the DBC Chairperson and Chief of Staff for further action.

Compliance with monthly required attendance will be reported to MEC (Medical Executive Committee) and QSVC in order to monitor compliance. Attendance will remain a standing agenda item at the above noted committees until 90% compliance is met and sustained for 6 consecutive months.

Moving forward, monthly audits will remain in place to monitor full compliance of the DBC program. Number of audits will be determined by utilizing the Joint Commission sampling size recommendations.

VHA requires the System Director to ensure employees are assigned prevention and management of disruptive behavior part 1 training at hire and "additional levels of PMDB [Prevention and Management of Disruptive Behavior] training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment."[87] The OIG found that 4 of 20 (20 percent) selected employees did not complete the required part 2 training based on the work area's risk level. This could result in lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Talent Management System

[87] DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments,* February 24, 2020*;* DUSHOM Memorandum*, Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements,* July 20, 2018.

Domain Manager reported that employees did not complete part 2 training due to face-to-face training restrictions to prevent exposure to COVID-19.

Recommendation 7

7. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[88]

Medical center concurred.

Target date for completion: December 31, 2021

Medical center response: The Medical Center Director reviewed and found no additional reasons for non-compliance. Due to the recent pandemic along with lack of a PMDB coordinator and trainers, the facility has an approximate back log of 324 employees requiring PMDB Part 2 Low and 204 employees requiring Part Two Moderate/High per TMS. A PMDB Coordinator and plan is in place to ensure compliance by December 31. The plan includes to have 15 instructors trained on PMDB by 8/27/21. PMDB classes will be offered and monitored weekly to ensure compliance and ensure all employees are trained by the target date.

The PMDB coordinator will monitor compliance with the assigned training and will be report to Disruptive Behavior Committee and at QSVC and noted in monthly minutes until 90% compliance for a 6-month period is met.

Moving forward, monthly audits will remain in place to monitor full compliance of the DBC program. Number of audits will be determined by utilizing the Joint Commission sampling size recommendations.

[88] The OIG recognizes that COVID-19 has affected facility operations and makes no comment on the timeline for safely accomplishing this important training.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed review of seven clinical and administrative areas and provided seven recommendations on systemic issues that may adversely affect patients. While the OIG's recommendations are not a comprehensive assessment of the caliber of services delivered at this medical center, they illuminate areas of concern and provide a road map for improvement. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines seven OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and ADPCS. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

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

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• None	• Required members consistently attend Surgical Work Group meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• Transferring providers identify the receiving provider on the VA *Inter-Facility Transfer Form* or facility-defined equivalent note. • Staff send the patient's active medication list to the receiving facility during the inter-facility transfer. • Nurse-to-nurse communication occurs between the sending and receiving facility.	• Transfers are monitored and evaluated as part of Veterans Health Administration's Quality Management Program.

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• Required members attend Disruptive Behavior Committee meetings. • Employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) medical center reporting to VISN 1.[1]

Table B.1. Profile for Manchester VA Medical Center (608)
(October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019	Medical Center Data FY 2020‡
Total medical care budget	$192,933,925	$230,351,174	$289,858,207
Number of:			
• Unique patients	26,530	27,277	25,762
• Outpatient visits	259,240	280,715	261,463
• Unique employees§	679	778	761
Type and number of operating beds:			
• Community living center	112	112	112
Average daily census:			
• Community living center	27	30	20

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

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

**October 1, 2017, through September 30, 2018.*
October 1, 2018, through September 30, 2019.
‡*October 1, 2019, through September 30, 2020.*
§*Unique employees involved in direct medical care (cost center 8200).*

[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) The VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Portsmouth, NH	608GA	2,067	1,234	Pulmonary/ Respiratory disease	EKG	Nutrition Pharmacy
Somersworth, NH	608GC	3,088	1,767	Dermatology Rheumatology Podiatry	EKG	Nutrition Pharmacy
Conway, NH	608GD	1,681	226	Rheumatology	EKG	Nutrition Pharmacy
Tilton, NH	608HA	2,518	900	Dermatology Endocrinology Rheumatology	EKG	Nutrition Pharmacy

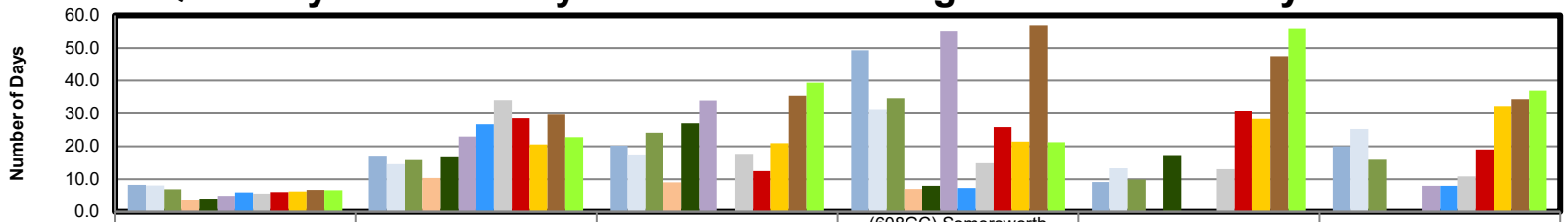
Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days



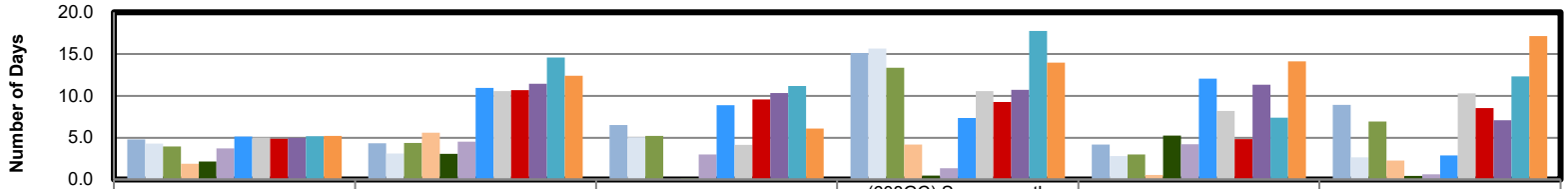
	VHA All	(608) Manchester, NH	(608GA) Portsmouth, NH	(608GC) Somersworth, NH	(608GD) Conway, NH	(608HA) Tilton, NH
JAN-FY19	8.3	16.8	20.2	49.3	9.1	20.0
FEB-FY19	8.1	14.5	17.5	31.4	13.3	25.3
MAR-FY19	6.9	15.8	24.1	34.7	9.9	15.9
APR-FY19	3.6	10.3	9.0	7.0	n/a	n/a
MAY-FY19	4.0	16.7	27.0	8.0	17.0	n/a
JUN-FY19	4.9	22.9	34.0	55.0	n/a	8.0
JUL-FY19	5.9	26.7	0.0	7.3	n/a	8.0
AUG-FY19	5.6	34.1	17.7	14.8	13.0	10.9
SEP-FY19	6.1	28.5	12.5	25.9	30.9	19.0
OCT-FY20	6.3	20.6	20.9	21.4	28.3	32.3
NOV-FY20	6.7	29.7	35.5	56.7	47.5	34.4
DEC-FY20	6.6	22.8	39.3	21.3	55.8	37.0

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the medical center's explanation for the increased wait times for community-based outpatient clinics in Manchester, Portsmouth, Somersworth, Conway, and Tilton, New Hampshire.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA All	(608) Manchester, NH	(608GA) Portsmouth, NH	(608GC) Somersworth, NH	(608GD) Conway, NH	(608HA) Tilton, NH
JAN-FY20	4.8	4.3	6.5	15.1	4.2	8.9
FEB-FY20	4.3	3.1	5.1	15.6	2.8	2.6
MAR-FY20	3.9	4.4	5.2	13.4	3.0	6.9
APR-FY20	1.9	5.6	0.0	4.2	0.6	2.3
MAY-FY20	2.1	3.1	0.2	0.5	5.2	0.4
JUN-FY20	3.7	4.5	3.0	1.4	4.2	0.6
JUL-FY20	5.1	11.0	8.9	7.3	12.1	2.9
AUG-FY20	5.0	10.6	4.1	10.6	8.2	10.3
SEP-FY20	4.9	10.7	9.6	9.3	4.8	8.6
OCT-FY21	5.0	11.4	10.4	10.7	11.3	7.1
NOV-FY21	5.2	14.6	11.2	17.7	7.4	12.3
DEC-FY21	5.2	12.4	6.1	14.0	14.1	17.2

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.

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

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

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

Measure	Definition	Desired Direction
AES Data Use	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HEDIS like – HED90_1	Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient behavioral health screening, prevention, immunization, and tobacco	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS composite score related to outpatient care for diabetes and ischemic heart disease	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
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
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

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	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
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 11, 2021

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

Subj: Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire

To: Director, Office of Healthcare Inspections (54CH01)

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

1. Thank you for the opportunity to review the findings from the Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire.

2. I concur with your findings and have reviewed the Medical Center Director's action plans. I am confident the action plans will result in successful resolution of each recommendation.

(Original signed by:)

Ryan S. Lilly

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: August 20, 2021

From: Director, Manchester VA Medical Center (608/00)

Subj: Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire

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

Manchester VA Medical Center has reviewed the OIG Report and concur with the recommendations. An action plan has been formulated and is attached.

(Original signed by:)

Julie Vose, OTR/L

Acting Medical Center Director for and on behalf of Kevin M. Forrest, FACHE

OIG Contact and Staff Acknowledgments

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