DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System in West Haven

CHIP REPORT | REPORT #21-00266-281 | SEPTEMBER 29, 2021

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Figure 1. *VA Connecticut Healthcare System in West Haven.*
Source: https://www.connecticut.va.gov/locations/directions.asp (*accessed August 10, 2021*).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Connecticut Healthcare System, which includes two campuses—the Newington VA Clinic and West Haven VA Medical Center—and multiple outpatient clinics in Connecticut. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

The OIG conducted an unannounced virtual review of the VA Connecticut Healthcare System 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 healthcare system'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 report may help this healthcare system and other Veterans Health Administration (VHA)

[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)."

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 eight recommendations to the Director, Chief of Staff, and Associate Director for Nursing and 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 healthcare system's leadership team consisted of the Director, Chief of Staff, Associate Director for Nursing and Patient Care Services, Deputy Director, and Assistant Director. Organizational communications and accountability were managed through a committee reporting structure, with Executive Leadership Council oversight of several working groups. Leaders monitored patient safety and care through the Quality, Safety, Value Council, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the healthcare system's leaders had worked together for nine months. The Deputy Director, who was permanently assigned in January 2012, was the most tenured leader. The Chief of Staff and Associate Director for Nursing and Patient Care Services, who were assigned in March and April 2020, were the newest members of the leadership team. The Assistant Director and Director had served in their positions since January 2017 and October 2019, respectively.

The OIG reviewed survey results and concluded that the Assistant Director had opportunities to reduce staff feelings of moral distress at work and improve employees' feelings about tolerance of discrimination in the workplace.[2] Selected patient experience survey scores generally reflected similar or higher care ratings than the VHA average. However, an opportunity exists for leaders to improve access to care and satisfaction with specialty providers for female veterans.

The OIG's review of the system's accreditation findings did not identify any substantial organizational risk factors. However, the OIG identified concerns with the patient safety and risk

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

management program related to identification of sentinel events and completion of institutional disclosures.[3]

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."[4] 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.[5]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL and Community Living Center SAIL measures and should continue to take actions to sustain and improve performance.[6]

COVID-19 Pandemic Readiness and Response

The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system 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 healthcare system complied with requirements for a committee responsible for quality, safety, and value oversight functions; the Systems Redesign and Improvement Program; and protected peer reviews.[7] However, the OIG identified a weakness with Surgical Performance Improvement Committee attendance.

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

[4] "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.)

[5] "Strategic Analytics for Improvement and Learning (SAIL) Value Model."

[6] 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.

[7] 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.

Medication Management

The healthcare system addressed many of the indicators of expected performance, including the availability of staff to receive medication shipments, use of proper names for medication orders, staff determination that patients met criteria for inclusion, completion of required testing prior to remdesivir administration, and reporting of adverse events. However, the OIG identified deficiencies with the provision of patient/caregiver education prior to the administration of remdesivir.

Mental Health

The healthcare system generally complied with requirements related to suicide prevention screening within emergency departments and urgent care centers. However, the OIG identified a weakness with the completion of required training by staff responsible for suicide safety plan development.

Care Coordination

The healthcare system met some of the requirements for inter-facility transfers, such as documentation of informed consent and transmission of patients' active medication lists to receiving facilities. However, the OIG identified deficiencies with the establishment of an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, identification of receiving physicians on the VA *Inter-Facility Transfer Form*, transmission of patients' advance directives to receiving facilities, and communication between nurses at sending and receiving facilities.

High-Risk Processes

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

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued eight recommendations for improvement to the System Director, Chief of Staff, and Associate Director for Nursing and Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for system 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.

Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 59–60, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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Contents

Purpose and Scope

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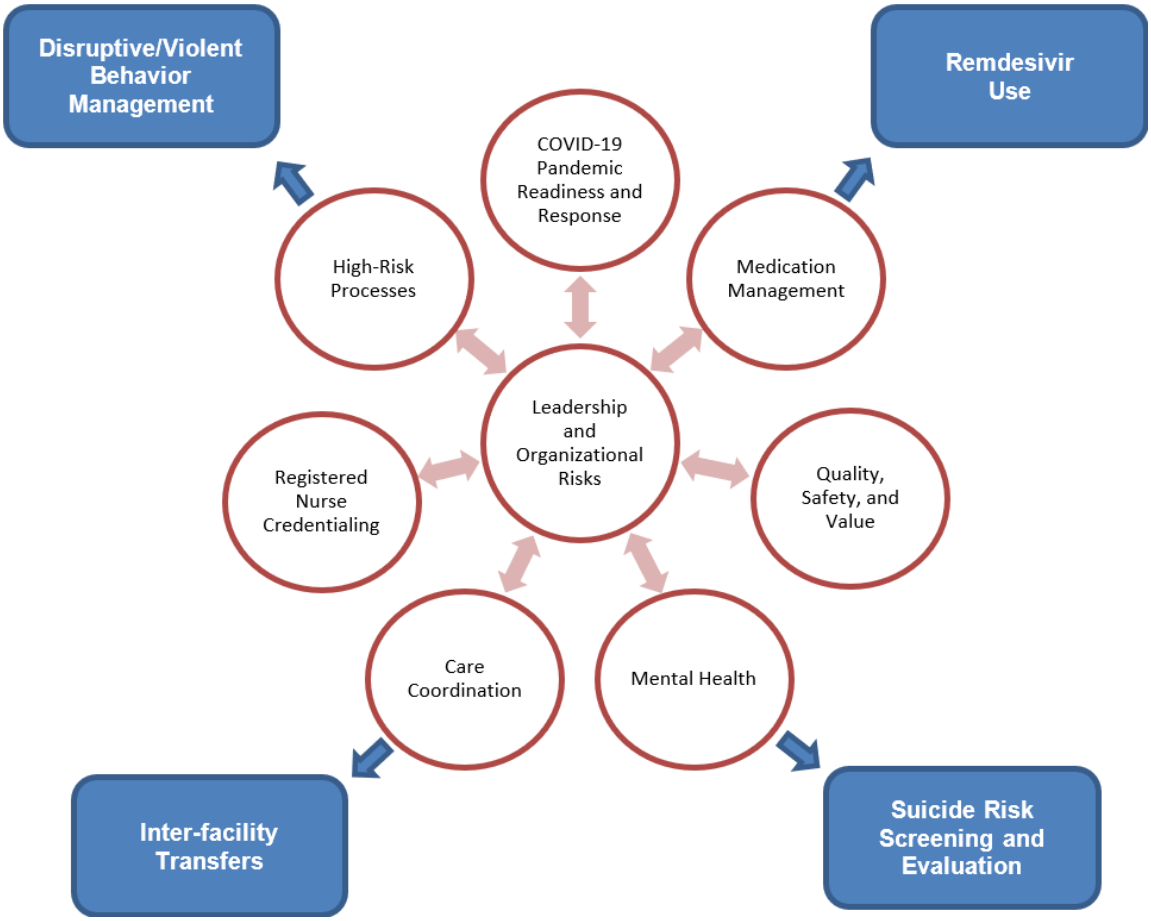

Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

The VA Connecticut Healthcare System includes the Newington VA Clinic, the West Haven VA Medical Center, and multiple outpatient clinics in Connecticut. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from March 23, 2019, through February 5, 2021, the last day of the unannounced multiday evaluation.[7] 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 healthcare system 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.[8] 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 healthcare system completes corrective actions. The System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the system leaders developed based on the reasons for noncompliance.

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

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

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

[8] 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.[9] To assess this healthcare system'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 healthcare system response
8. VHA performance data (healthcare system)
9. VHA performance data (community living center (CLC))[10]

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 healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the Director, Chief of Staff, Associate Director for Nursing and Patient Care Services (ADNPCS), Deputy Director, and Assistant Director. The Chief of Staff and ADNPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

[10] 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.

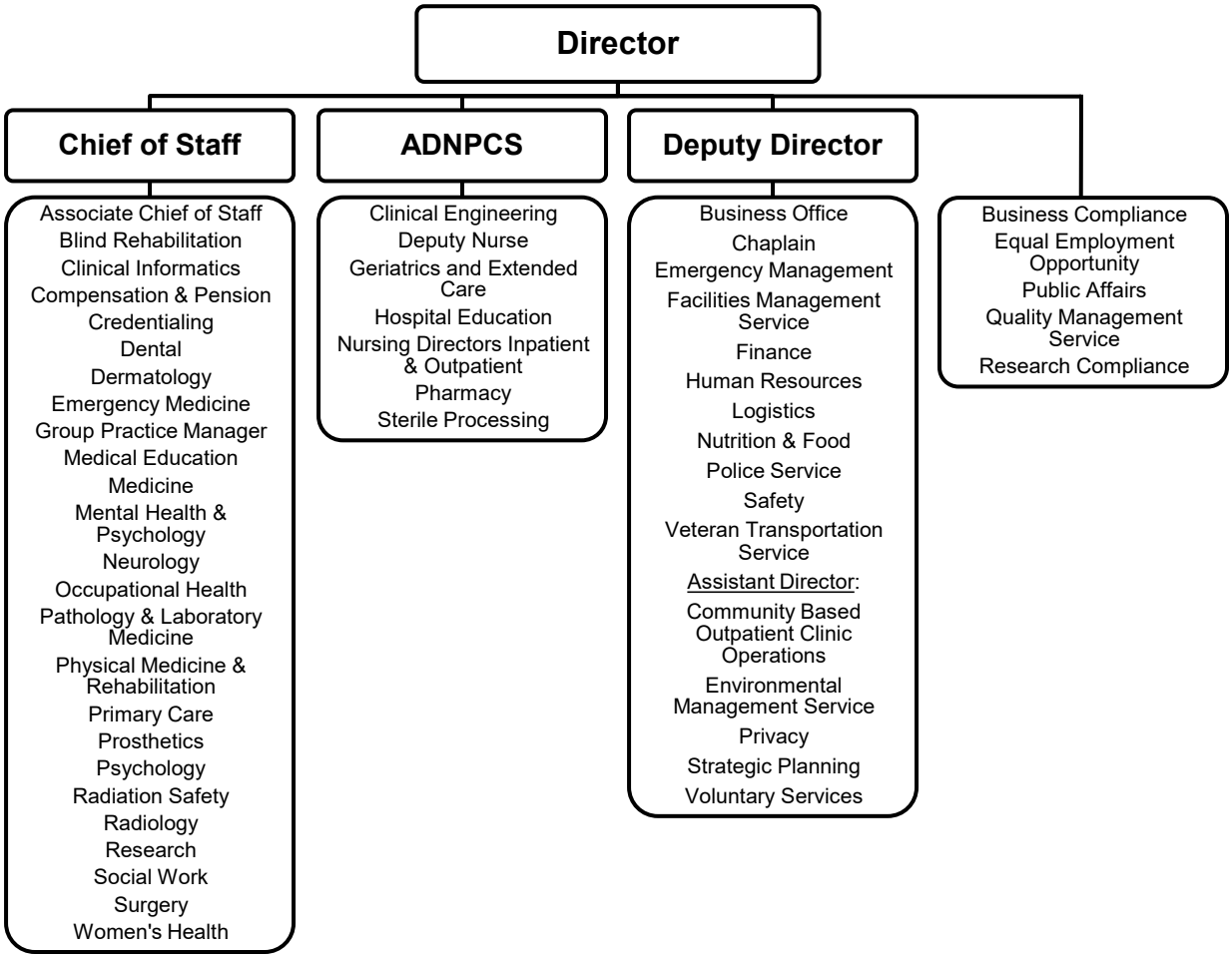

Figure 3. *Healthcare system organizational chart.*

Source: VA Connecticut Healthcare System (received February 1, 2021).

At the time of the OIG inspection, the executive team had worked together for nine months. The Director had been in place since October 2019. The newest members of the executive team, the Chief of Staff and ADNPCS, were permanently assigned in March and April 2020, respectively. The Deputy Director and Assistant Director had the longest tenure and were assigned in January 2012 and January 2017, respectively (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
System Director	October 13, 2019
Chief of Staff	March 29, 2020
Associate Director for Nursing and Patient Care Services	April 26, 2020
Deputy Director	January 29, 2012
Assistant Director	January 22, 2017

Source: VA Connecticut Healthcare System Senior Strategic Business Partner (received February 1, 2021).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADNPCS, and Deputy Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

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

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

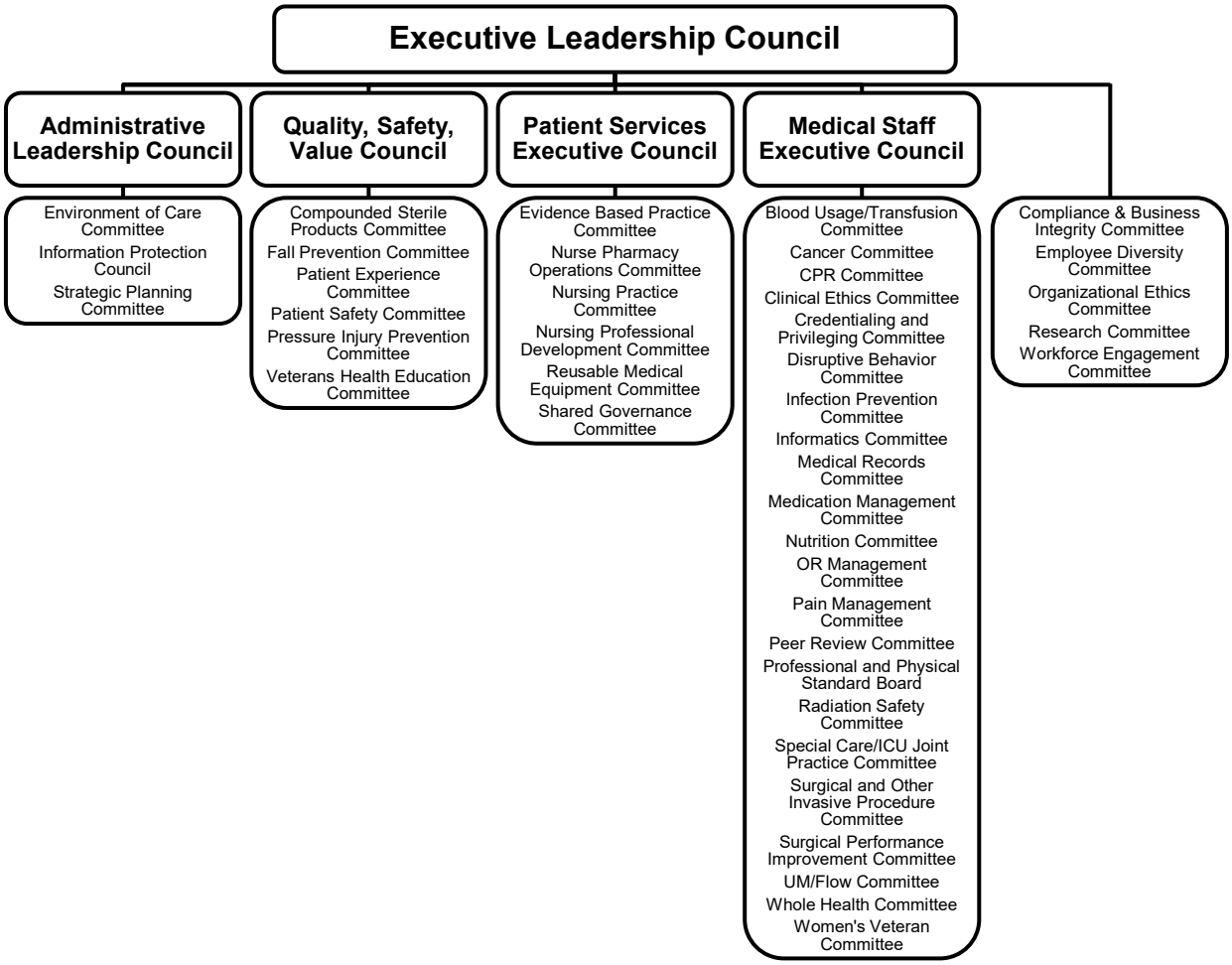

Figure 4. *Healthcare system committee reporting structure.*

Source: VA Connecticut Healthcare System (received February 1, 2021).

CPR = Cardiopulmonary Resuscitation.
ICU = Intensive Care Unit.
OR = Operating Room.
UM = Utilization Management.

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $737,617,432 increased over 11 percent compared to the previous year's budget of $662,778,519.[11] When asked about the effect of this change on the healthcare system's operations, the Director indicated that the budget was adequate and that the system had to streamline resources to be good stewards of taxpayer dollars.

[11] VHA Support Service Center.

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.[12] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[13] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[14]

The system did not report any occupational shortages in the 2020 survey. The Chief of Staff reported that strategies to address provider shortages included hiring physician assistants and advanced practice registered nurses and using affiliate provider resources. The ADNPCS also reported the system is not experiencing a nursing shortage at this time; however, salary differences between the healthcare system and its affiliates contribute to recruiting difficulties for operating room and interventional radiology nurses and mental health advanced practice registered nurses.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[15] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[16] 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 healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[17] Table 2 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the healthcare system average for the selected

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

[13] 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.

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

[15] "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.)

[16] "AES Survey History."

[17] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADNPCS, Deputy Director, and Assistant Director.

survey leadership questions was similar to the VHA average. The leaders' scores were consistently higher than the VHA average.[18]

Table 2. Survey Results on Employee Attitudes toward Healthcare System Leaders (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADNPCS Average	Deputy Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	73.7	86.6	98.8	80.3	92.9	78.1
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	3.6	4.4	4.6	4.5	4.4	3.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.7	4.4	4.5	4.2	4.6	4.0
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.8	4.3	4.9	4.6	4.6	3.9

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.*

[18] 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.

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[19] The healthcare system average for the selected survey questions was similar to the VHA average. Scores related to four of the executive leaders were similar to or better than those for VHA and the healthcare system. However, the Assistant Director had an opportunity 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 Assistant Director reported that efforts to improve employee engagement included implementing "Coffee and Conversation" in which a system leader spends one-on-one time with an employee. In addition, all leaders participate in Leadership Rounding and Team Connecticut Huddles, which are the facility's town hall meetings.

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADNPCS Average	Deputy Director Average	Asst. 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	4.1	4.9	4.1	4.5	4.1
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	4.3	4.6	3.8	4.6	3.8

[19] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADNPCS, Deputy Director, and Assistant Director.

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADNPCS Average	Deputy Director Average	Asst. 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	1.4	1.3	1.4	0.6	1.8

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

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment."[20] 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.[21] The Director reported implementing strategies that support VA's "Stand Up to Stop Harassment Now!" campaign.[22] The Director also reported meeting with the Diversity Advisory Council, Equal Employment Opportunity Manager, and Public Affairs Officer weekly.

Table 4 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The healthcare system and executive leadership team averages for the selected survey questions were generally similar to or better than the VHA average. However, the Assistant Director may have an opportunity to improve employees' feelings about tolerance of discrimination in the workplace. Overall, system leaders appeared to maintain an environment where staff felt respected and safe.

[20] "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.

[21] "Stand Up to Stop Harassment Now!"

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

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADNPCS Average	Deputy Director Average	Asst. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.9	3.9	4.5	4.8	4.1	4.7	3.9
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.1	4.0	4.3	4.6	4.4	4.6	3.8
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.7	4.5	4.8	3.9	4.6	3.8

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

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 5 provides relevant survey results for VHA and the healthcare system.[23]

For this healthcare system, the overall patient satisfaction survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

[23] Ratings are based on responses by patients who received care at this healthcare system.

Table 5. Survey Results on Patient Experience (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	71.3
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	89.7
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	88.1

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 20 and 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.[24] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 6–8). The results for male respondents were consistently more positive than the corresponding VHA averages, while those for female respondents were generally similar to or more favorable than female VHA patients nationally. However, an opportunity exists for leaders to improve access to care and satisfaction with specialty providers for female veterans. System leaders appeared to be actively engaged with male and female patients (for example, by conducting veteran town halls, leadership rounding, and using survey results to learn the perceptions of their experiences and implement changes).

[24] "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 6. Inpatient Survey Results on Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	72.1	–‡
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	85.9	–‡
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	88.5	87.1

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

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

The healthcare system averages are based on 486–491 male and 9–10 female respondents, depending on the question.

‡*The VA Connecticut Healthcare System did not receive enough responses for the question.*

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

Questions	Scoring	VHA*		Healthcare System	
		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	60.9	42.1
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	67.5	60.0
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	82.0	85.7

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 healthcare system averages are based on 561–1,655 male and 35–83 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*		Healthcare System	
		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	53.3	39.2
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	59.3	73.5
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	76.7	67.8

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

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

The healthcare system averages are based on 569–1,745 male and 27–72 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. Table 9 summarizes the relevant system inspections most recently performed by the OIG. At the time of the OIG review, the Chief, Quality Management reported that the healthcare system had not been surveyed by The Joint Commission since the previous CHIP site visit.[25] In addition, the Chief,

[25] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." Compliance with TJC standards "facilitates risk reduction and performance improvement."

Quality Management reported that three recommendations remained open from a prior focused OIG report published on November 20, 2019. All but seven recommendations for improvement issued during the March 2019 CHIP site visit were closed. The Chief, Quality Management provided the most recent action plans for the previous CHIP and focused reports.

The OIG team also noted the healthcare system's current accreditation by the College of American Pathologists.[26]

Table 9. Office of Inspector General Inspections

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Deficiencies in Sterile Processing Services and Decreased Surgical Volume at the VA Connecticut Healthcare System, Newington, Connecticut, West Haven, Connecticut,* Report No. 19-00075-14, November 20, 2019)	December 2018 February 2019	11	3*
OIG (*Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, Connecticut*, Report No.18-04675-23, November 20, 2019)	March 2019	13	7

Source: OIG.

**As of September 2021, one recommendation remained open.*
As of September 2021, one recommendation remained open.

Identified Factors Related to Possible Lapses in Care and Healthcare System 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

[26] 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.

able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

Table 10 lists the reported patient safety events from March 23, 2019 (the prior OIG CHIP site visit), through February 3, 2021.[27]

Table 10. Summary of Selected Organizational Risk Factors (March 23, 2019, through February 3, 2021)

Factor	Number of Occurrences
Sentinel Events	2
Institutional Disclosures	17
Large-Scale Disclosures	0

Source: VA Connecticut Healthcare System's Chief Quality Management for sentinel events and institutional disclosures (received February 3 and 4, 2021, respectively), and the Risk Manager for large-scale disclosures (received February 1, 2021).

The Director spoke knowledgeably about serious adverse event reporting; the previous 24-hour safety events are reported at the Director's daily morning conference. As it relates to institutional disclosure, the Director reported that discussion of the adverse event takes place to determine if criteria for disclosure is met, then a decision is made on how to proceed. Furthermore, the healthcare system's process for serious event follow-up includes a review by the Chief, Quality Management and Patient Safety Manager.

The OIG team identified two areas of concern for patient harm: identifying sentinel events and conducting institutional disclosures for adverse events, as required. For the healthcare system's patient safety program, the OIG requested a list of sentinel events since March 23, 2019, and

[27] 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 VA Connecticut Healthcare System is a highest complexity (1a) affiliated system 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."

quality management staff reported no sentinel events for that time period. The OIG team reviewed VHA's sentinel event definition with quality management staff and recommended a re-review of the healthcare system's reported adverse events for that same time period to determine if any reported events met sentinel event criteria.[28] At the completion of the re-review, quality management staff identified two sentinel events. Although the Director stated that safety events reported from the previous day are discussed at the morning meeting with quality management staff, the system has an opportunity to review its processes to ensure timely identification of sentinel events and implementation of actions to mitigate future occurrences.

As it relates to disclosure of adverse events that occur when the patient is under the care of the healthcare system, the OIG requested a list of completed institutional disclosures since March 23, 2019. Quality management staff provided a list of five disclosures completed for this time frame; however, the OIG identified 16 institutional disclosure notes entered into patients' medical records for the same time period. The discrepancy was discussed with the Chief, Quality Management, and an updated list was received. The revised disclosure list included a total of 17 events. The system has an opportunity to review its processes to ensure timely completion of institutional disclosures for applicable adverse patient events and implementation of actions to mitigate future occurrences.

Veterans Health Administration Performance Data for the Healthcare System

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 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 healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the VA Connecticut Healthcare System'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 rating (of) primary care (PC) provider, patient-centered medical home (PCMH) same day appointment (appt), care transition, and specialty care (SC) care coordination). Metrics in the fourth and fifth quintiles are those that need improvement and

[28] 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."

[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.)

[30] "Strategic Analytics for Improvement and Learning (SAIL) Value Model."

are denoted in orange and red, respectively (for example, mental health (MH) experience (exp) of care, adjusted length of stay (LOS), and healthcare (HC) associated (assoc) infections).[31]

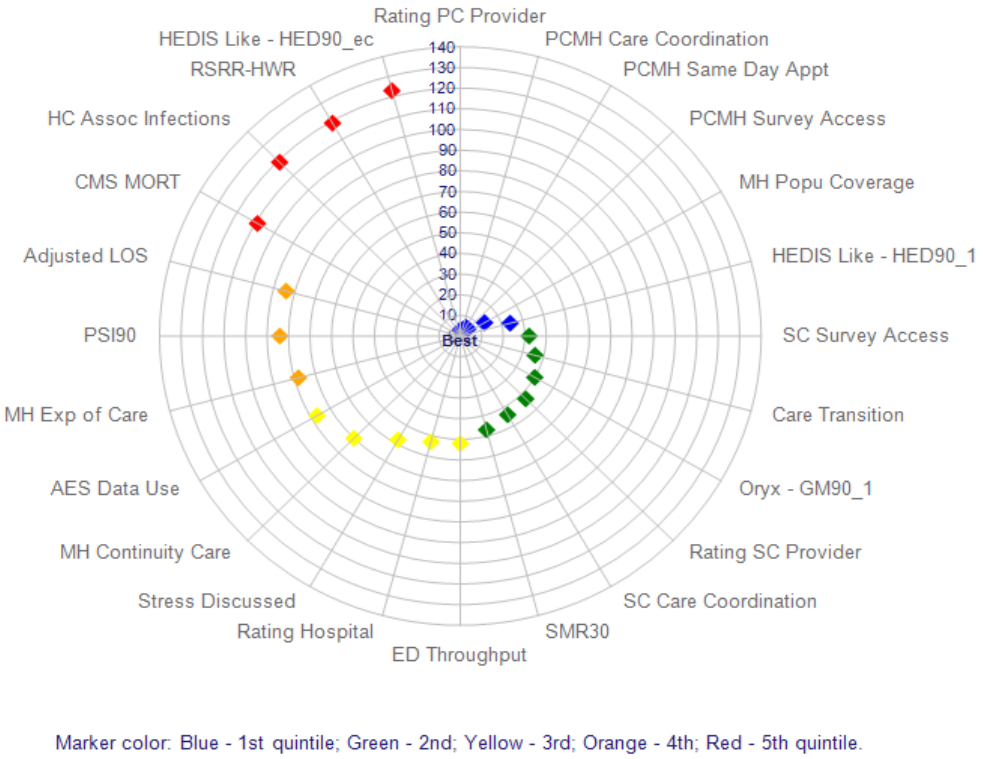

Figure 5. *System quality of care and efficiency metric rankings, FY 2020 quarter 3 (as of June 30, 2020).*

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 &

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

[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.

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

Figures 6 illustrates the healthcare system's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the VA Connecticut Healthcare System's CLC metrics with high performance (blue data points) in the first quintile (for example, in the areas of urinary tract infections (UTI)–long-stay (LS), falls with major injury (LS), and new or worse pressure ulcer (PU)–short-stay (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, rehospitalized after nursing home (NH) admission (SS), outpatient emergency department (ED) visit (SS), and catheter in bladder (LS)).[34]

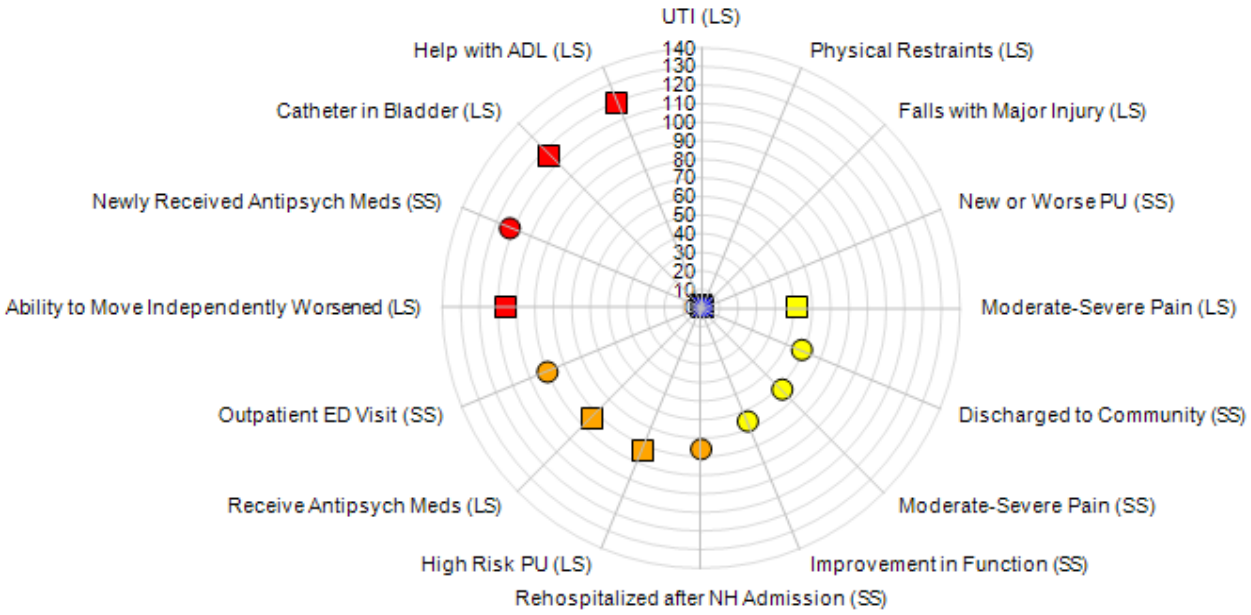

Figure 6. *West Haven CLC quality measure rankings, FY 2020 quarter 3 (as of June 30, 2020).*

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.* "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."

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

Leadership and Organizational Risks Findings

The healthcare system's executive leadership team's five key positions were permanently assigned at the time of the OIG's visit. The Director had served in the role since 2019, and the Deputy Director and Assistant Director had been in their positions for several years.

The Director noted the adequacy of the FY 2020 budget, and the Chief of Staff and ADNPCS were able to discuss strategies to address clinical occupational shortages.

Selected employee satisfaction survey responses generally demonstrated satisfaction with leaders and maintenance of an environment where staff felt generally respected and discrimination was not tolerated. Patient experience survey data indicated satisfaction with the care provided, and selected healthcare system survey results for male and female respondents were generally more favorable than those for male and female VHA patients nationally.

The OIG's review of the system's accreditation findings did not identify any substantial organizational risk factors. However, the OIG identified concerns with the patient safety and risk management program related to identification of sentinel events and completion of institutional disclosures. The executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models and should continue to take actions to sustain and 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 healthcare system 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 healthcare system 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 healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

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[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 healthcare system's committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

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

The OIG reviewers also assessed the healthcare system'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 healthcare system'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 healthcare system'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; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select

[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.)

specialty programs."[50] The healthcare system'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 healthcare system complied with requirements for a committee responsible for QSV oversight functions, the Systems Redesign and Improvement Program, and protected peer reviews. However, the OIG identified a deficiency with Surgical Performance Improvement Committee attendance.

VHA requires medical facilities with surgery programs to have a surgical work group that meets at least monthly and includes the Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[53] The OIG reviewed Surgical Performance Improvement Committee meeting minutes from January through December 2020 and found that the Chief of Staff or the designee, the Associate Chief of Staff, did not attend 9 of 12 (75 percent) meetings. The leader's lack of involvement resulted in the review and analysis of surgery program data without the perspective of this key member. The Chief of Surgery indicated that competing priorities and COVID-19 pandemic demands likely contributed to inconsistent attendance.

[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).

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures the Chief of Staff regularly attends Surgical Performance Improvement Committee meetings.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The System Director reviewed and evaluated additional reasons for noncompliance and did not identify any additional reasons. The facility's Associate Chief of Staff regularly attends the surgical Performance Improvement Committee meetings, as the Chief of Staff designee. Beginning August 2021, the Chief of Surgery will document attendance for all core members at each committee meeting using an attendance log. The Chief, Quality Management Service will review monthly attendance log for each core member's attendance at each committee meeting. Target of 90% compliance will be achieved and monitoring for sustainment for six consecutive months. The core members' attendance compliance will be reported monthly to the Quality, Safety and Value Council.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[54] 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."[55]

VA requires all RNs to hold at least one active, unencumbered license.[56] 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.[57] 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.[58] 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.[59]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 44 RNs hired from January 1, 2020, through 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 the credentialing files for 30 of the 44 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

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

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

[56] 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."

[57] 38 U.S.C. § 7402.

[58] VHA Directive 2012-030.

[59] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The healthcare system generally met the requirements listed above. The OIG made no recommendations.

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[60] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[61]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[62] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[63]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[64] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[65]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of 13 patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments
- Medication orders used proper name

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

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

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

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

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

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

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
  - Potential pregnancy
  - Kidney assessment (estimated glomerular filtration rate)[66]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[67]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the healthcare system addressed many of the indicators of expected performance listed above. However, the OIG identified deficiencies with patient/caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, inform patients and/or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients and/or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[68] Of the 13 patients who received remdesivir, the OIG found that healthcare providers did not

- provide 69 percent of patients or caregivers the *Fact Sheet for Patients and Parents/Caregivers*,
- inform 46 percent of patients or caregivers that remdesivir was not an FDA-approved drug,
- provide 92 percent of patients or caregivers the option to refuse remdesivir,
- advise 15 percent of patients or caregivers of the known risks and benefits of remdesivir, and

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

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

[68] *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir),* May 1, 2020. VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

- advise 92 percent of patients or caregivers of alternatives to receiving remdesivir prior to administration.[69]

This could have resulted in patients and caregivers lacking the information needed to make a fully informed decision to receive the medication.[70] The Hospitalist/Infectious Disease Physician stated that the requirement to document that the patient or caregiver had been given the *Fact Sheet for Patients and Parents/Caregivers* was not clear, and consistent documentation in the medical record did not always occur for all required elements. However, the physician reported believing that the documentation in the medical record met the intent of the Emergency Use Authorization fact sheet. Additionally, the Chief of Staff reported following the National Institutes of Health guidelines for the treatment of COVID-19.

Given the FDA's approval of remdesivir for use in adult patients requiring hospitalization for the treatment of COVID-19, the OIG made no recommendations related to requirements under the Emergency Use Authorization.[71]

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

[70] VHA Handbook 1004.01(4), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended January 4, 2021.

[71] "FDA News Release: FDA Approved First Treatment for COVID-19."

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[72] 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.[73] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[74]

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.[75] 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.[76] The healthcare system 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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[72] "Preventing Suicide," Centers for Disease Control and Prevention, accessed December 9, 2020, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

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

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

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

[76] 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 46 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 OIG found the healthcare system generally complied with the completion of all required elements in the Columbia-Suicide Severity Rating Scale. However, the OIG identified a deficiency with staff training.

VHA requires staff to complete mandatory suicide safety plan training prior to developing suicide safety plans with patients.[77] The OIG reviewed the training records for 30 staff responsible for suicide safety plan development and found that 17 lacked evidence that staff completed the mandatory training. Lack of staff training may lead to inadequate safety planning with patients who are at risk for suicide. The Director, Psychiatric Emergency Room; Suicide Prevention Coordinator; and Chief, Hospital Education reported being unaware that the training was mandatory.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that staff complete mandatory suicide safety plan training prior to developing suicide safety plans.

Healthcare system concurred.

Target date for completion: April 30, 2022

Healthcare system response: The Chief of Staff reviewed and evaluated additional reasons for noncompliance and did not identify any additional reasons. The Chief, Psychiatry Service and Chief, Emergency Medicine identified the staff responsible for suicide safety plan development in the emergency department/urgent care center, notified the Chief, Hospital Education, who then assigned the required TMS [Talent Management System] training. Beginning September 2021, the Chief, Hospital Education will run a monthly TMS report to identify all employees due for the safety plan training and ensure compliance with completion. The Chief of Staff will monitor compliance monthly until 90% compliance or greater is achieved and then monitor for six consecutive months to demonstrate sustainment. The TMS completion compliance data will be reported to the Quality, Safety, and Value Council monthly.

[77] 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.

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.[78]

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."[79] 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.[80]

The healthcare system 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 healthcare system 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 44 patients who were transferred from the healthcare system 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 healthcare system met some of the elements of performance for inter-facility transfers. However, the OIG identified deficiencies with the establishment of a facility policy, monitoring and evaluation of inter-facility transfers, identification of receiving physicians on the VA *Inter-Facility Transfer Form*, transmission of patients' advance directives to receiving facilities, and communication between nurses at sending and receiving facilities.

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

[79] VHA Directive 1094.

[80] 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 Medical Facility Director to ensure that each VA facility has a written policy to ensure "the safe, appropriate, orderly, and timely transfer of patients."[81] While the OIG found the healthcare system had an inter-facility transfer policy, the policy was expired. Failure to maintain a current inter-facility transfer policy could result in lack of coordination between facilities to provide seamless care for patients through the transfer process. The Chief, Quality Management reported that the Chief of Staff's office had not updated the policy due to competing demands related to the COVID-19 pandemic. The Chief, Quality Management also reported that healthcare system staff were working with services on updating expired policies to comply with VHA standards.

Recommendation 3

3. The System Director evaluates and determines additional reasons for noncompliance and maintains a current written policy to ensure the safe, appropriate, orderly, and timely transfer of patients.

Healthcare system concurred.

Target date for completion: November 30, 2021

Healthcare system response: The System Director evaluated any additional reasons for noncompliance and did not identify any additional reasons. The System Director agrees with the VISN wide standard operating procedure for interfacility transfer which has been developed in conjunction with adherence to the VHA Directive 1094 Inter-Facility Transfer Policy. This Standard Operating Procedure for Inter-Facility Transfer was reviewed at the VISN 1 Quality, Safety and Value Committee on August 18, 2021, and will be finalized by September 30, 2021. Beginning in October 2021, appropriate staff will be educated on the updated standard operating procedure and it will be considered implemented by October 31, 2021.

VHA requires that the Chief of Staff and ADNPCS ensure "all transfers are monitored and evaluated as part of VHA's Quality Management Program."[82] The OIG requested meeting minutes from the committee responsible for oversight of the transfer process from January 1, 2020, through January 30, 2021. The OIG found that there was no committee responsible for oversight or evidence that staff monitored and evaluated transfers. Lack of monitoring inter-facility patient transfers could inhibit the healthcare system's ongoing performance improvement activities. The Chief, Quality Management reported that monitoring and evaluating transfers were discontinued as a result of new leadership in the case management department, and staff were unaware of the ongoing requirement.

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

[82] VHA Directive 1094.

Recommendation 4

4. The Chief of Staff and Associate Director for Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure all transfers are monitored and evaluated as part of Veterans Health Administration's Quality Management Program.

Healthcare system concurred.

Target date for completion: April 30, 2022

Healthcare system response: The Chief of Staff and Associate Director for Nursing and Patient Care Services evaluated any additional reasons for noncompliance with monitoring transfers out of the facility and did not identify any additional reasons. The transfer note template was updated to include required elements as of March 15, 2021. Quality management staff will audit the transfer process and report results to the facility's Quality, Safety and Value Committee monthly. Audits of 10 transfers per month will be conducted and if less than 10 transfers, 100% of transfers will be reviewed. Results of the monthly audits will be presented to the Quality, Safety and Value committee until 90% compliance is achieved with required elements for six consecutive months. An audit log will be used to track all required elements for transfer.

VHA requires the Chief of Staff and ADNPCS to ensure the referring physician records the "identification of the transferring and receiving physicians" on the *Inter-Facility Transfer Form* or facility-defined equivalent note.[83] The OIG estimated that referring physicians did not identify the receiving physician for 45 percent of patient transfers.[84] This could result in the unsafe transfer of patients and inability to monitor and evaluate transfer data. The Chief, Emergency Medicine Service reported that for patients transferred from the Newington Urgent Care Center, physician-to-physician report may not occur due to limited patient evaluation by the provider prior to transfer. The Chief, Emergency Medicine Service also reported that patient transfers from the West Haven Emergency Department may be facilitated by a specialty service, and emergency department providers are not directly involved or provided with a receiving physician's name.

[83] VHA Directive 1094.

[84] The OIG estimated that 95 percent of the time, the true compliance rate is between 39.5 and 69.6 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 5

5. The System Director and Associate Director for Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that referring physicians identify the receiving physicians on the *Inter-Facility Transfer Form* or facility-defined equivalent note.

Healthcare system concurred.

Target date for completion: April 30, 2022

Healthcare system response: The System Director, Chief of Staff, and Associate Director for Nursing and Patient Care Services evaluated risks and reasons for noncompliance related to identifying the receiving physician during the interfacility transfer process and did not identify any additional reasons for noncompliance. Staff involved in transferring patients to another facility were educated on changes made to the templated note via a TMS training implemented on March 15, 2021, and compliance was monitored by the Nurse Manager for the Emergency Department. The note was immediately put into use. Quality management staff will audit the transfer process and report results to the facility's Quality, Safety and Value Committee monthly. Audits of 10 transfers per month will be conducted and if less than 10 transfers, 100% of transfers will be reviewed and results presented to the Quality, Safety and Value committee until 90% compliance with required elements for transfer is reached for six consecutive months. An audit log will be used to track all required elements for transfer.

VHA requires the Chief of Staff and ADNPCS to ensure that "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."[85] The OIG estimated that staff did not send the patient's advance directive to the receiving facility during 92 percent of transfers.[86] As a result, there was no assurance that receiving facility staff could determine patient preferences regarding future healthcare decisions.[87] The Chief, Emergency Medicine Service reported that the documentation process for transfers is cumbersome and consists of completing multiple documents in a very stressful and time-sensitive clinical environment. The Chief, Emergency Medicine Service also reported that not sending the patient's advance directive to the receiving facility is the result of a poor process. Because only 12 patients were identified as having an advance directive, the OIG made no recommendation.

[85] VHA Directive 1094.

[86] The OIG estimated that 95 percent of the time, the true compliance rate is between 0.0 and 28.6 percent, which is statistically significantly below the 90 percent benchmark.

[87] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives,* December 24, 2013.

VHA requires that the Chief of Staff and ADNPCS ensure nurse-to-nurse communication occurs during the inter-facility transfer process to allow for questions and answers from staff at both sending and receiving facilities.[88] The OIG estimated that nurse-to-nurse communication did not occur for 64 percent of patient transfers, based on the electronic health records reviewed.[89] This could have resulted in receiving staff lacking the information needed to care for patients. The Emergency Department Nurse Manager reported that nurse-to-nurse communication occurred but the name of the receiving nurse was not documented.

Recommendation 6

6. The Chief of Staff and Associate Director for Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure nurse-to-nurse communication occurs during the inter-facility transfer process.

Healthcare system concurred.

Target date for completion: April 30, 2022

Healthcare system response: The Chief of Staff and Associate Director for Nursing and Patient Care Services evaluated risks and reasons for noncompliance related to ensuring nurse-to-nurse communication during the interfacility transfer process and did not identify any additional reasons for noncompliance. Staff involved in transferring patients to another facility were educated on changes made to the templated note and it was immediately put into use in March 2021. Quality management staff will audit the transfer process and report results to the facility's Quality, Safety and Value Committee monthly. Audits of 10 transfers per month will be conducted and if less than 10 transfers, 100% of transfers will be reviewed and presented to the Quality, Safety and Value committee until 90% compliance with required elements for transfer is reached for six consecutive months. An audit log will be used to track all required elements for transfer.

[88] VHA Directive 1094.

[89] The OIG estimated that 95 percent of the time, the true compliance rate is between 22.5 and 51.1 percent, which is statistically significantly below the 90 percent benchmark.

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."[90] 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."[91] 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[92]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[93]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[94]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[95]

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

[91] VHA Directive 2012-026.

[92] 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."

[93] 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."

[94] 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."

[95] 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.[96] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[97] 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 healthcare system complied with 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.

VHA requires that the Chief of Staff and Nurse Executive (ADNPCS) are responsible for establishing a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; the patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and Union Safety Committee.[98]

The OIG requested Disruptive Behavior Committee meeting minutes from February 2020 through January 2021; however, the OIG was only provided with nine months of meeting minutes. The OIG found that administrative support staff did not attend any of the meetings and the Risk Manager did not attend seven of nine meetings. This could have resulted in a lack of knowledge and expertise when assessing patients' disruptive behavior. The Disruptive Behavior Committee Chair reported that the Chief of Staff did not assign an administrative support staff member or a replacement for the Risk Manager, who resigned in September 2020. The Chief of Staff stated that clerical assistance was offered but not used and could not provide a reason for the Risk Manager's absence in the meetings prior to the resignation or why an alternate was not assigned. The Chief of Staff also reported that a Risk Manager was hired in January 2021 and has been assigned to attend Disruptive Behavior Committee meetings.

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

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

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

Recommendation 7

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

Healthcare system concurred.

Target date for completion: January 31, 2022

Healthcare system response: The Chief of Staff and Associate Director for Patient Care Services reviewed and evaluated additional reasons for noncompliance and did not discover any additional reasons.[99] The Chair, Disruptive Behavior Committee, is responsible for the Disruptive Behavior Committee meetings attendance log. The committee added both risk managers as regular attendees to the meeting on March 15, 2021. An administrative support person was added on July 19, 2021. The Chair, Disruptive Behavior Committee will capture attendance at the beginning of each committee meeting for each required member and compliance will be determined by the number of meetings attended divided by the number of meetings held for each required member. Compliance will be monitored until a 90% or greater compliance rate is achieved and sustainment demonstrated for six consecutive months.

VHA requires that staff are assigned part 1 of the prevention and management of disruptive behavior training at hire and additional levels of training, based on the risk level assigned to their work area.[100] The OIG found that none of the six staff, whose workplace was deemed as high-risk, completed the required part 3 training. This could result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Chief, Hospital Education reported that prevention and management of disruptive behavior part 3 training was placed on hold due to the COVID-19 pandemic.

Recommendation 8

8. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that staff complete the required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[101]

[99] The Associate Director for Patient Care Services is also known as the ADNPCS at this healthcare system.

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

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

Healthcare system concurred.

Target date for completion: August 31, 2022

Healthcare system response: The System Director reviewed and evaluated additional reasons for noncompliance and did not identify any additional reasons. The Chief, Hospital Education reviewed and confirmed the requirements for Prevention and Management of Disruptive Behavior training. Virtual classes for Prevention and Management of Disruptive Behavior Part 2 for Low Risk Workplace training for all staff began on February 8, 2021, following approval of the virtual platform. On July 15, 2020, Prevention and Management of Disruptive Behavior Level 1 training was included in virtual New Employee Orientation. The Chief, Hospital Education will monitor training via the compliance deficiency report which will be run monthly for all levels of training until compliance rates reach 90% or greater and sustained for six consecutive months. The compliance deficiency report will be shared with healthcare system supervisors to ensure compliance. Compliance will be reported to the facility's Quality, Safety and Value Committee monthly. Prevention and Management of Disruptive Behavior Part 2 for Moderate/High Risk and Part 3 Containment Techniques training has been on hold since March 12, 2020, due to the pandemic. Infection prevention leaders in collaboration with the executive leadership team have not approved in-person training for Prevention and Management of Disruptive Behavior Part 2 for Moderate/High Risk Workplaces and Part 3 Containment Techniques. The Hospital education service will implement the plan to train all staff requiring Prevention and Management of Disruptive Behavior Part 2 for Moderate/High Risk Workplaces and Part 3 Containment Techniques training when permitted.

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 healthcare system, the OIG conducted a detailed review of eight clinical and administrative areas and provided eight 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 healthcare system, 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 eight 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 ADNPCS. 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 healthcare system response • VHA performance data (healthcare system) • 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 healthcare system 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	• Chief of Staff regularly attends Surgical Performance Improvement Committee meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• Staff complete mandatory suicide safety plan training prior to developing suicide safety plans.

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• Referring physicians identify receiving physicians on the *Inter-Facility Transfer Form* or facility-defined equivalent note. • Nurse-to-nurse communication occurs during the inter-facility transfer process.	• A current written policy to ensure the safe, appropriate, orderly, and timely transfer of patients is maintained. • All transfers are monitored and evaluated as part of VHA's Quality Management Program.
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 representatives attend Disruptive Behavior Committee meetings. • Staff complete the required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

Appendix B: Healthcare System Profile

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

Table B.1. Profile for VA Connecticut Healthcare System (689)
(October 1, 2017, through September 30, 2020)

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019	Healthcare System Data FY 2020‡
Total medical care budget	$653,614,081	$662,778,519	$737,617,432
Number of:			
• Unique patients	58,687	58,264	55,559
• Outpatient visits	770,394	784,712	723,014
• Unique employees§	3,424	3,455	3,486
Type and number of operating beds:			
• Blind rehabilitation	10	10	10
• Community living center	40	40	40
• Domiciliary	32	32	32
• Intermediate	8	8	8
• Medicine	50	50	50
• Mental health	28	28	28
• Neurology	2	2	2
• Surgery	21	21	21
Average daily census:			
• Blind rehabilitation	9	9	4
• Community living center	21	19	18
• Domiciliary	24	23	9
• Medicine	32	33	37

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

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019	Healthcare System Data FY 2020‡
• Mental health	14	13	11
• Neurology	1	1	0
• Surgery	11	7	9

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

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

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

Appendix C: VA Outpatient Clinic Profiles

The VA outpatient clinics in communities within the catchment area of the healthcare system 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
Newington, CT	689A4	24,771	16,766	Cardiology Dermatology Endocrinology Eye General surgery GYN Hematology/ Oncology Infectious disease Nephrology Neurology Plastic Podiatry	EKG EMG Laboratory & Pathology Radiology Vascular lab	Dental Nutrition Pharmacy

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Newington, CT, cont.				Poly-Trauma Pulmonary/ Respiratory disease Rehab physician Rheumatology Spinal cord injury Urology Vascular		
Waterbury, CT	689GA	2,508	756	Dermatology Nephrology	–	Nutrition Pharmacy Weight management
Stamford, CT	689GB	1,710	656	Dermatology	–	Nutrition Pharmacy Weight management
Willimantic, CT	689GC	2,365	709	Dermatology General surgery Nephrology Neurology	–	Nutrition Pharmacy Weight management
Winsted, CT	689GD	2,109	881	Dermatology Nephrology Neurology	–	Nutrition Pharmacy Weight management
Danbury, CT	689GE	2,001	736	Dermatology Nephrology Neurology	–	Nutrition Pharmacy Weight management

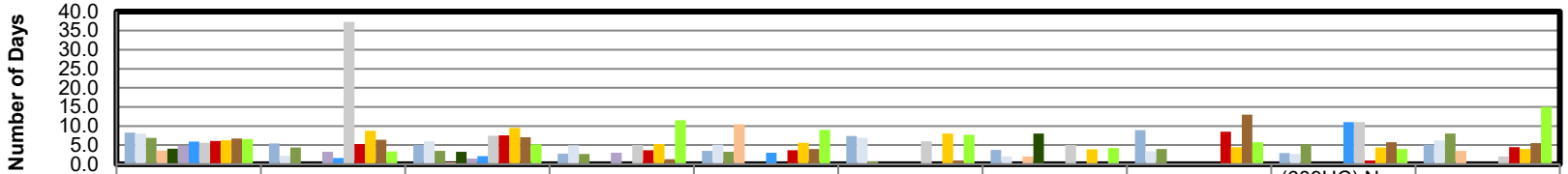
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
New London, CT	689HC	6,625	1,919	Dermatology Nephrology Neurology Plastic	–	Nutrition Pharmacy Weight management
Errera, CT	689QA	642	1,624	Anesthesia	–	Nutrition Pharmacy Weight management

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

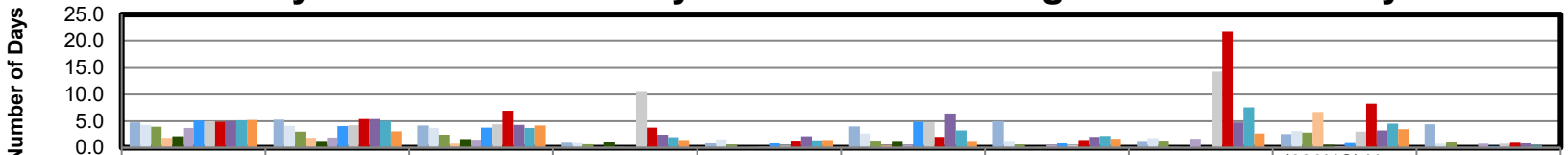


	VHA All	(689) West Haven, CT	(689A4) Newington, CT	(689GA) Waterbury, CT	(689GB) Stamford, CT	(689GC) Willimantic, CT	(689GD) Winsted, CT	(689GE) Danbury, CT	(689HC) New London, CT (John J. McGuirk)	(689QA) Errera, CT
JAN-FY19	8.3	5.5	5.1	2.8	3.5	7.4	3.7	8.9	2.9	5.1
FEB-FY19	8.1	2.2	6.0	4.9	5.1	6.9	2.0	3.5	2.7	6.3
MAR-FY19	6.9	4.4	3.5	2.7	3.3	0.8	0.0	4.0	5.2	8.0
APR-FY19	3.6	0.0	0.5	0.0	10.5	n/a	2.0	n/a	n/a	3.5
MAY-FY19	4.0	0.3	3.2	n/a	n/a	n/a	8.0	0.0	n/a	n/a
JUN-FY19	4.9	3.3	1.5	3.0	0.0	0.0	0.0	0.0	0.0	n/a
JUL-FY19	5.9	1.7	2.2	0.0	3.0	n/a	0.0	n/a	11.0	n/a
AUG-FY19	5.6	37.3	7.5	5.0	0.0	6.0	5.0	n/a	11.0	2.0
SEP-FY19	6.1	5.3	7.5	3.7	3.7	0.0	0.0	8.5	1.0	4.5
OCT-FY20	6.3	8.8	9.5	5.3	5.6	8.0	3.9	4.5	4.4	4.0
NOV-FY20	6.7	6.4	7.0	1.3	4.0	1.0	0.0	13.0	5.8	5.5
DEC-FY20	6.6	3.3	5.2	11.5	9.0	7.8	4.2	5.8	4.0	15.0

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 omitted (689GF) Orange, CT, as no workload/encounters or services were reported.

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."



	VHA All	(689) West Haven, CT	(689A4) Newington, CT	(689GA) Waterbury, CT	(689GB) Stamford, CT	(689GC) Willimantic, CT	(689GD) Winsted, CT	(689GE) Danbury, CT	(689HC) New London, CT (John J. McGuirk)	(689QA) Errera, CT
JAN-FY20	4.8	5.3	4.2	1.0	0.8	4.0	5.0	1.3	2.5	4.4
FEB-FY20	4.3	4.1	3.7	0.9	1.6	2.7	1.3	1.8	3.1	0.8
MAR-FY20	3.9	3.0	2.5	0.6	0.6	1.3	0.6	1.4	2.9	1.0
APR-FY20	1.9	1.8	0.7	0.0	0.0	0.4	0.0	0.1	6.7	0.0
MAY-FY20	2.1	1.3	1.6	1.2	0.2	1.3	0.2	0.0	0.5	0.0
JUN-FY20	3.7	1.9	1.5	0.1	0.2	0.6	0.5	1.7	0.3	0.8
JUL-FY20	5.1	4.0	3.8	0.0	0.8	4.9	0.8	0.0	0.9	0.3
AUG-FY20	5.0	4.3	4.4	10.5	0.4	4.8	0.5	14.3	3.0	0.8
SEP-FY20	4.9	5.4	7.0	3.8	1.3	2.1	1.5	21.8	8.3	1.0
OCT-FY21	5.0	5.4	4.3	2.4	2.1	6.5	2.1	4.7	3.3	0.8
NOV-FY21	5.2	5.1	3.7	2.0	1.4	3.3	2.2	7.6	4.5	0.4
DEC-FY21	5.2	3.1	4.2	1.5	1.5	1.3	1.7	2.7	3.5	0.0

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 omitted (689GF) Orange, CT as no workload/encounters or services were reported.

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

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES Data Use	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
Care transition	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Health care associated infections	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
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
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 27, 2021

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

Subj: Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System in West Haven

To: Director, Office of Healthcare Inspections (54CH06)

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

1. I have reviewed and concur with the response for the draft report of the Comprehensive Healthcare Inspection of the VA Connecticut Health Care System in West Haven.

2. I have reviewed the Healthcare System Director's action plan and projected completion dates. I concur with the plan and have complete confidence that the plan will be effective. VISN 1 will assist the Healthcare System's leadership in reaching full compliance in a timely manner.

3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Ryan S. Lilly, MPA
Director
VA New England Healthcare System

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: August 24, 2021

From: Director, VA Connecticut Healthcare System (689/00)

Subj: Comprehensive Healthcare Inspection of the VA Connecticut Health Care System in West Haven

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, CT.

2. I have reviewed and concur with the recommendations, findings and action plans set forth in this report.

(Original signed by:)

Alfred A Montoya Jr., MHA, FACHE, VHA-CM
Medical Center Director

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