DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico

CHIP REPORT | REPORT #21-00270-04 | OCTOBER 26, 2021

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Figure 1. *VA Caribbean Healthcare System in San Juan, Puerto Rico.*
Source: https://vaww.va.gov/directory/guide/ (*accessed March 10, 2021*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
DBC	Disruptive Behavior Committee
ED	emergency department
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
PMDB	prevention and management of disruptive behavior
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WBRA	Workplace Behavioral Risk Assessment

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 Caribbean Healthcare System, which includes the San Juan VA Medical Center and multiple outpatient clinics in Puerto Rico and the U.S. Virgin Islands. 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 Caribbean Healthcare System during the week of March 22, 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 10 recommendations to the Director, Chief of Staff, and Associate Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the healthcare system's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, Deputy Director, and Associate Director for Operations.[2] Organizational communications and accountability were managed through a committee reporting structure, with Executive Governance Board oversight of several working groups. Leaders monitored patient safety and care through the Quality, Safety and Values 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 in their positions for less than one month. However, they had worked together in other capacities at the system for over two years. The Associate Director and Associate Director for Patient Care Services, the most tenured members of the executive team, had served in their positions since July and August 2015, respectively. The Chief of Staff, the newest member of the leadership team, assumed the role in February 2021 after serving as the Deputy Chief of Staff for five years.

The OIG reviewed employee survey results and noted general satisfaction with leaders and maintenance of an environment where staff felt respected and discrimination was not tolerated. However, the OIG noted opportunities for the Director and Associate Director for Patient Care Services to reduce staff feelings of moral distress at work.[3] Selected patient experience survey scores implied general satisfaction with care but highlighted opportunities for leaders to improve experiences for male and female veterans. Leaders reported efforts to address female veterans' experiences by recruiting a new care coordinator and increasing outreach activities.

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[2] The Associate Director for Operations will be referred to as the Associate Director throughout the report.

[3] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events.[4] The OIG identified concerns with the system's completion of institutional disclosures and the actions taken following serious adverse events. Specifically, seven sentinel events reviewed had no evidence of institutional disclosure and three sentinel event-related root cause analyses did not have actions or associated outcome measures.

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

The executive leaders spoke knowledgeably within their scope of responsibilities about VHA data and system-level factors contributing to poor performance on specific SAIL measures. Leaders were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences.

COVID-19 Pandemic Readiness and Response

The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this 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. However, the OIG identified inconsistent member attendance at Surgical Workgroup meetings.

Registered Nurse Credentialing

The OIG determined that registered nurses hired between January 1, 2020, and February 15, 2021, were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with primary source verification.

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

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

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

Medication Management

The OIG determined that the healthcare system met many of the requirements for the use of remdesivir. However, the OIG found deficiencies with patient/caregiver education.

Care Coordination

The healthcare system generally met expectations for inter-facility transfers. However, the OIG identified deficiencies with documented transmission of patients' active medication lists and advance directives to receiving facilities and nurse-to-nurse communication between facilities.

High-Risk Processes

The healthcare system met some of the requirements for the management of disruptive and violent behavior. However, the OIG found deficiencies with Disruptive Behavior Committee meeting attendance, documentation of patient notification of Orders of Behavioral Restriction, completion of the annual Workplace Behavior Risk Assessment, and staff training.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued 10 recommendations for improvement to the Director, Chief of Staff, and Associate Director for Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for healthcare 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 63–64, 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.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Caribbean 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)
6. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
7. Care coordination (spotlighting inter-facility transfers)
8. High-risk processes (examining the management of disruptive and violent behavior)

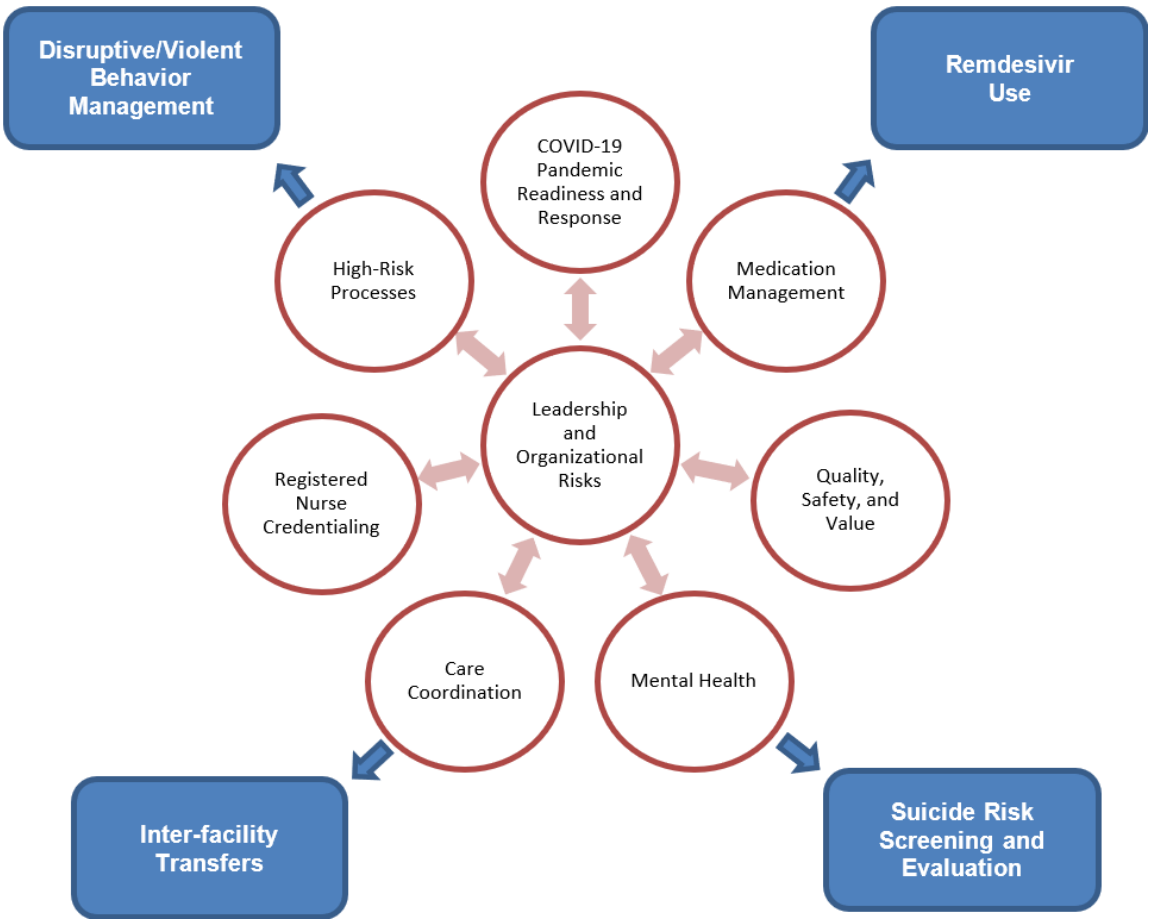

***Figure 2**. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. Source: VA OIG.*

Methodology

The VA Caribbean Healthcare System includes the San Juan VA Medical Center and multiple outpatient clinics in Puerto Rico and the U.S. Virgin Islands. 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 October 22, 2016, through March 26, 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 Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that 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 Clinical Assessment Program site visit to the completion of the unannounced, multiday virtual CHIP visit in March 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, which included a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Deputy Director, and Associate Director for Operations.[11] The Chief of Staff and ADPCS 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.

[11] The Associate Director for Operations will be referred to as the Associate Director throughout the report.

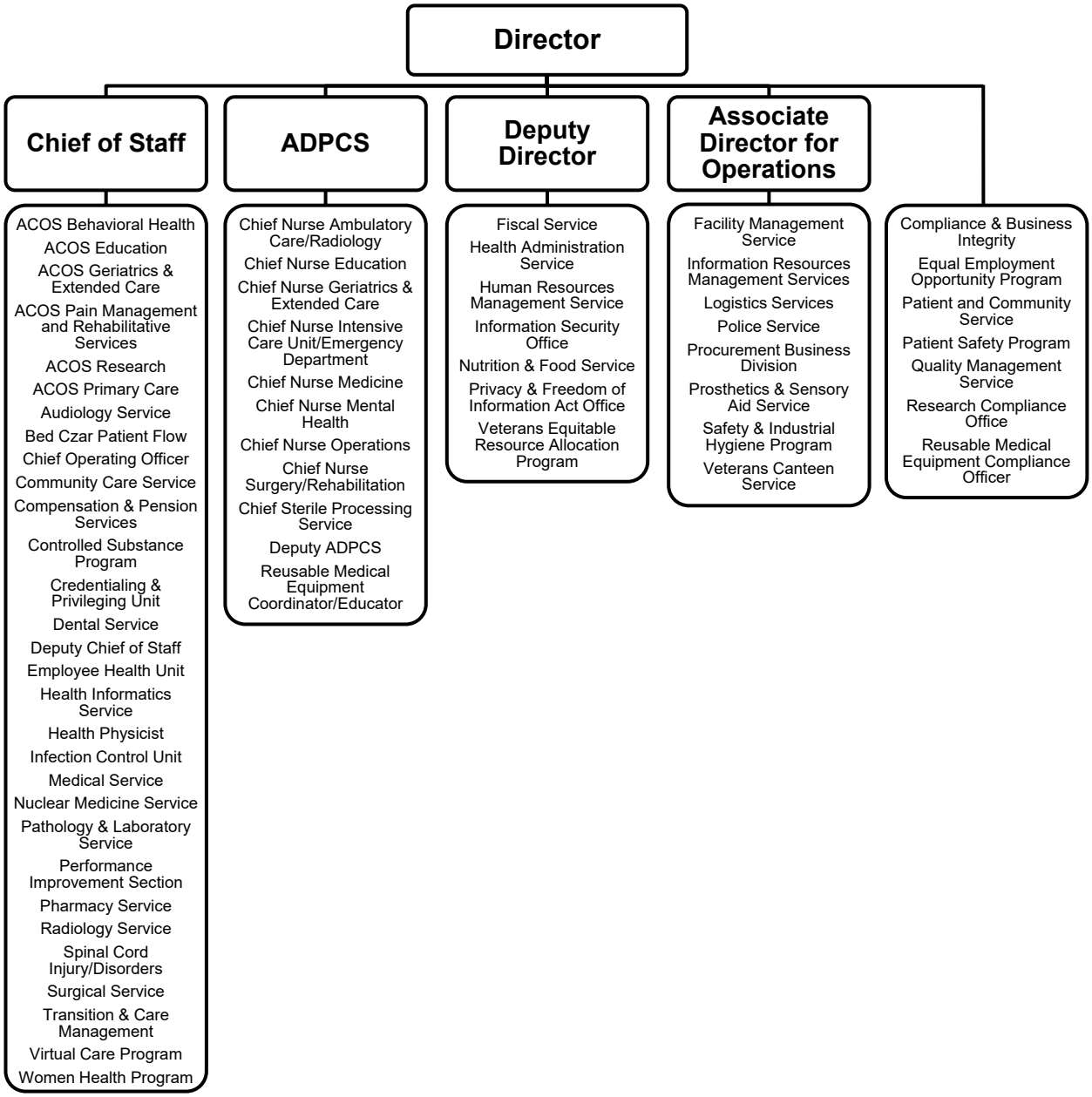

Figure 3. *Healthcare system organizational chart.*

Source: VA Caribbean Healthcare System (received March 22, 2021).

ACOS = Associate Chief of Staff.

At the time of the OIG inspection, the healthcare system's leaders had worked together in their positions for less than one month, although they had worked together in other capacities at the system for over two years (see table 1). The Chief of Staff, the newest member of the leadership team, assumed the role in February 2021 after serving as the Deputy Chief of Staff for five years.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	February 19, 2019
Chief of Staff	February 28, 2021
Associate Director for Patient Care Services	August 9, 2015
Deputy Director	August 19, 2018
Associate Director	July 12, 2015

Source: VA Caribbean Healthcare System Human Resources Officer (received March 22, 2021).

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

The executive leaders spoke knowledgeably within their scope of responsibilities about specific healthcare system and CLC Strategic Analytics for Improvement and Learning (SAIL) measures contributing to poor performance. In individual interviews, the executive leadership team members were also able to speak in depth 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 Governance Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Governance Board oversaw various working groups, such as the Operations Council, Professional Development and Advocacy Council, and Clinical and Nurse Executive Boards. Healthcare system leaders monitored patient safety and care through the Quality, Safety and Values Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Governance Board (see figure 4).

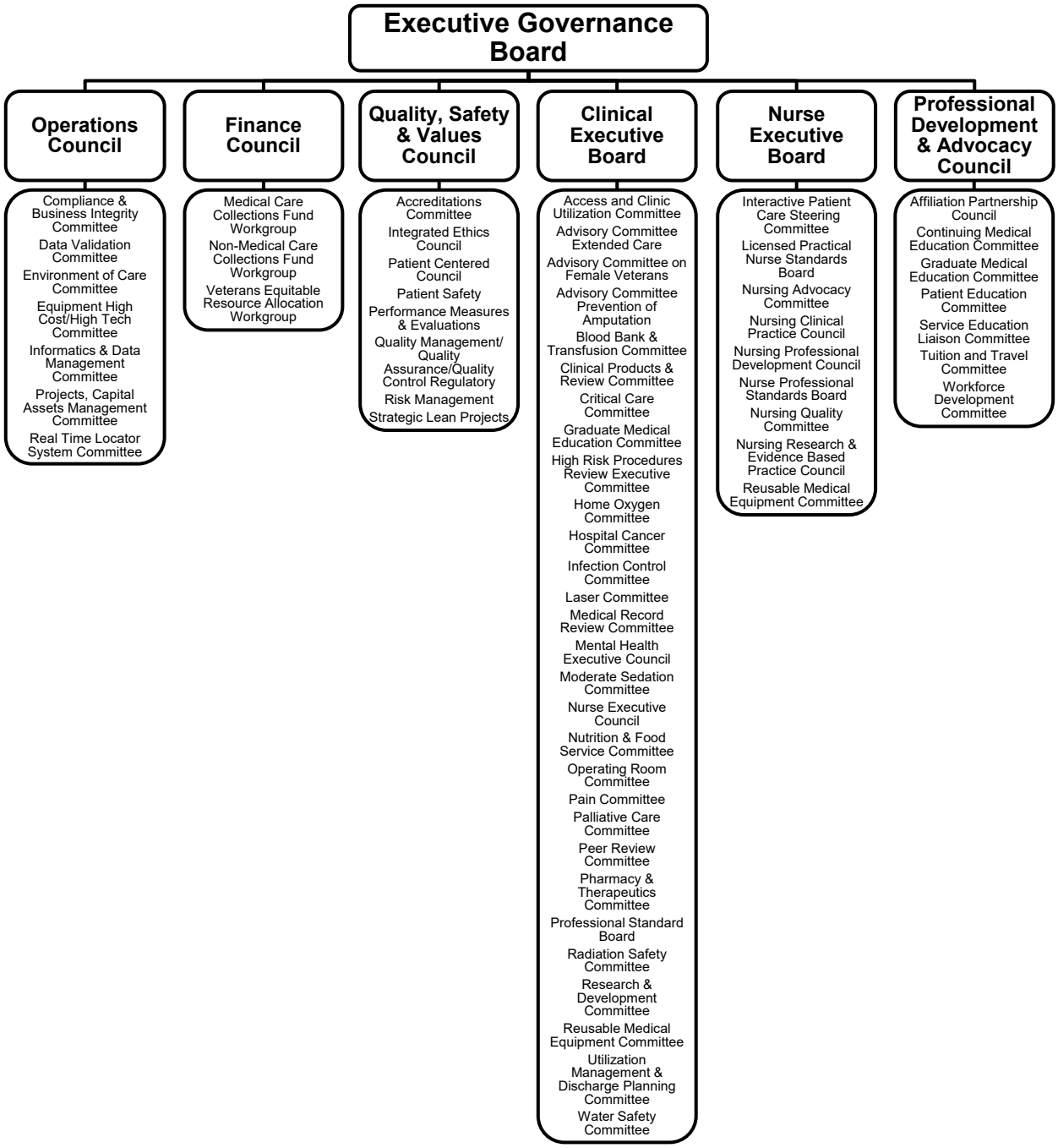

Figure 4. *Healthcare system committee reporting structure.*

Source: VA Caribbean Healthcare System (received March 22, 2021).

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $705,199,825 increased by over six percent compared to the previous year's budget of $661,583,926.[12] When asked about the effect of this change on the healthcare system's operations, the Director reported using funds to ensure adequate staffing during the pandemic, enhance the healthcare system's ability to perform diagnostic studies, and increase specialty care services. Additionally, the Director shared plans to expand the Home Based Community Care program.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[13] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[14] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[15]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[16] The executive leaders confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection and reported ongoing challenges with recruiting and retaining physicians primarily due to the high cost of living in Puerto Rico and inability to compete with private sector salaries. In addition, the executive leadership team attributed longstanding challenges recruiting qualified human resources and financial management employees due to the need for highly specialized knowledge.

The leaders also described ongoing efforts to address staffing shortages, which included adjusting pay scales, offering incentives such as the Education Debt Reduction Plan, using nurse practitioners and physician assistants, and expanding the academic residency program. The Chief of Staff mentioned social workers as a new area of concern with over 45 vacant positions, and discussed actions underway to enhance the social work scope of practice to include the ability to work independently and allow for greater advancement opportunities.

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[12] VHA Support Service Center.

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

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

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

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

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Thoracic Surgery	1. Human Resources Management
2. Cardiovascular/Thoracic Surgeon	2. Financial Management
3. Orthopedic Surgery	3. –*
4. Radiation Oncology	4. –*
5. Critical Care	5. –*

Source: VA OIG.

**Indicates no shortage identified in the OIG Occupational Staffing Shortage FY 2020 report.*

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[17] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[18] 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.[19] Table 3 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. Staff generally rated the Director, Chief of Staff, Deputy Director, and Associate Director similar to or higher than VHA and the healthcare system. Staff rated the ADPCS similar to or lower than VHA and the healthcare system.[20] The Deputy

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

[18] "AES Survey History."

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

[20] 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.

Director spoke about continuing the journey of becoming a high reliability organization, improving employee engagement, and creating opportunities for growth.[21]

Table 3. 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	ADPCS Average	Deputy Director Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	71.7	76.3	81.3	65.7	76.9	88.1
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	3.4	4.1	3.7	3.3	3.6	4.3
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.6	4.2	3.9	3.5	3.8	4.4

[21] "VHA's Vision for a High Reliability Organization," Health Services Research & Development, accessed August 20, 2021, https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm?ForumMenu=summer20-1. A high reliability organization is defined as "an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results."

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director Average	Assoc. Director Average
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.9	4.3	4.0	4.0	4.1	4.4

Source: VA All Employee Survey (accessed February 22, 2021).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[22] Overall, staff rated the leaders similar to or more favorable than VHA and the healthcare system. However, the Director and ADPCS have opportunities to reduce employee feelings of moral distress at work. The Director attributed the moral distress scores to the challenges that staff faced following hurricanes, earthquakes, and the pandemic.

Table 4. 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	ADPCS Average	Deputy Director Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.2	4.0	3.7	3.9	4.4

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director Average	Assoc. Director Average
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	4.0	4.0	3.6	3.9	4.1
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	1.6	2.0	1.2	1.8	1.6	1.0

Source: VA All Employee Survey (accessed February 22, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[23] 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.[24]

During the virtual review, the Associate Chief of Staff for Education Service (former acting Chief of Staff) reported working on a national collaborative to promote patient safety and reduce health disparities and described the system's journey to acquire knowledge regarding equity,

[23] "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.

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

unconscious bias, humility, and cultural competency.[25] In addition, the Associate Chief of Staff for Education Service shared that the system's Lesbian, Gay, Bisexual, and Transgender Program educates staff on special and vulnerable populations to expand awareness and increase sensitivity.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. With the exception of the ADPCS, employees rated the executive team similar to or higher than VHA and the healthcare system for perception of respect and intolerance of discrimination. The ADPCS attributed the lower scores to new leaders learning to trust each other and conveyed that within the patient care service line, discrimination is not tolerated and is investigated and addressed immediately.

Table 5. 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	ADPCS Average	Deputy Director Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.9	3.9	4.2	4.2	3.6	4.1	4.4
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.1	4.1	4.3	4.3	3.9	4.2	4.4
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	4.1	3.9	3.5	3.9	4.3

Source: VA All Employee Survey (accessed February 22, 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

[25] The former acting Chief of Staff was assigned to this position from December 9, 2019, to February 28, 2021.

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 6 provides relevant survey results for VHA and the VA Caribbean Healthcare System.[26] Patients rated this healthcare system's inpatient care notably higher than the VHA average but scored outpatient care similar to or lower than VHA patients nationally. Generally, inpatients appeared satisfied with the care provided and would recommend this hospital to family and friends.

Table 6. 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	83.0
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	81.9
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	81.2

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by

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

2048.[27] 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 7–9). The male respondents generally rated inpatient care similar to or more favorable than the corresponding VHA averages but rated their outpatient experience similar to or lower than VHA averages. Female veterans rated their inpatient interaction with nurses notably higher than male respondents and VHA averages but scored overall satisfaction and contact with physicians lower. Female respondents rated their patient-centered medical home care experience similar to or higher than VHA averages but rated specialty care lower than VHA averages.

The scores highlighted opportunities for leaders to improve experiences for male and female veterans. Leaders attributed the lower scores to the pandemic and the need to decrease clinic visits and transition to virtual care. In addition, the Chief of Staff cited lack of care coordination and specialty services working in silos as contributing factors to the lower scores. To improve satisfaction and attract female veterans to the system, the Associate Director reported creating a clinic devoted to women's health. In addition, the ADPCS described hosting a weekly radio segment to engage and inform female veterans about VHA resources and benefits and stated that the healthcare system was recruiting a women's care coordinator to supplement the women's health program.

Table 7. 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	83.7	54.7
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	89.3	70.3

[27] "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.

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
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	82.2	94.7

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

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

† The healthcare system averages are based on 508–512 male and 10 female respondents, depending on the question.

Table 8. 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	51.6	66.2
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).	59.5	53.0	57.4	59.5
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).	74.0	68.9	77.6	83.9

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 527–1,322 male and 28–49 female respondents, depending on the question.

Table 9. 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	46.3	26.2
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	53.2	50.3
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	72.8	66.2

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 646–1,368 male and 22–45 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.[28] Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint

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

Commission (TJC).[29] At the time of the OIG review, the healthcare system had closed all open recommendations for improvement issued since the previous OIG Clinical Assessment Program review in October 2016.[30]

Table 10. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Healthcare Inspection: Alleged Unreported Surgical Incidents and Deaths, VA Caribbean Healthcare System, San Juan, Puerto Rico*, Report No. 16-03150-277, June 27, 2017)	June 2016	0	–
OIG (*Clinical Assessment Program Review of the VA Caribbean Healthcare System, San Juan, Puerto Rico,* Report No. 16-00551-128, March 8, 2017*)*	October 2016	12	0
OIG (*Alleged Poor Quality of Cancer Care at the VA Caribbean Healthcare System, San Juan, Puerto Rico*, Report No. 18-01879-232, September 26, 2019)	October 2018	7	0
TJC Hospital Accreditation	June 2019	28	0
TJC Behavioral Health Care Accreditation		6	0
TJC Home Care Accreditation		3	0
TJC Laboratory	February 2021	0	0

Source: OIG and TJC (inspection/survey results received from the Accreditation Coordinator and Program Analyst on March 22, 2021).

[29] 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."

[30] VA OIG, *Clinical Assessment Program Review of the VA Caribbean Healthcare System, San Juan, Puerto Rico*, Report No. 16-00551-128, March 8, 2017; VA OIG, *Alleged Poor Quality of Cancer Care at the VA Caribbean Healthcare System, San Juan, Puerto Rico,* Report No. 18-01879-232, September 26, 2019.

The OIG also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[31] Additional results included the Long Term Care Institute's inspection of the system's CLC and the Paralyzed Veterans of America's inspection of the facility's Spinal Cord Injuries and Disorders Center.[32] The system had one open recommendation each from the Commission on Accreditation of Rehabilitation Facilities, Long Term Care Institute, and Paralyzed Veterans of America inspections. The Health System Specialist for Quality Management provided information on the actions being taken to address the three open recommendations.

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

[31] 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.

[32] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings." The Paralyzed Veterans of America inspection took place February 5-6, 2019. This veterans service organization review does not result in accreditation status.

Table 11 lists the reported patient safety events from October 22, 2016 (the prior OIG Clinical Assessment Program site visit), through March 22, 2021.[33]

Table 11. Summary of Selected Organizational Risk Factors (October 22, 2016, through March 22, 2021)

Factor	Number of Occurrences
Sentinel Events	15
Institutional Disclosures	22
Large-Scale Disclosures	0

Source: VA Caribbean Healthcare System's Risk Manager and Patient Safety Specialist (received April 30, 2021).

The Director spoke knowledgeably about serious adverse event reporting processes, which included reviewing occurrences through the healthcare system's daily briefing and discussing cases with a patient safety manager and executive leaders. In addition, the Director reported assigning an executive leader to be on call to address urgent matters after business hours. Further, the Director relayed that the Chief of Staff, in consultation with quality management and patient safety staff, determines when an institutional disclosure is warranted.

However, the OIG identified concerns with the system's completion of institutional disclosures and the actions taken following serious adverse events. Specifically, the OIG determined that healthcare system staff did not perform institutional disclosures on seven sentinel events. Additionally, three sentinel event-related root cause analyses (incidents involving a death after a fall, a wrong site surgery, and an inadvertent medication discontinuation) did not have actions or associated outcome measures to minimize future patient risk. Quality management staff acknowledged the need to identify strategies to enhance the system's root cause analysis and

[33] 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 Caribbean 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."

institutional disclosure processes. The Director recognized the need to adopt a more agile method to connect the dots between a recommendation and its completion to ensure implementation of quality improvement processes.

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."[34] 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.[35]

Figure 5 illustrates the healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2020. Figure 5 shows the VA Caribbean Healthcare System 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 mental health (MH) continuity (of) care, hospital rating (HCAHPS), and care transition). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, health care (HC) associated (assoc) infections, adjusted length of stay (LOS), emergency department (ED) throughput, and stress discussed).[36]

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

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

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

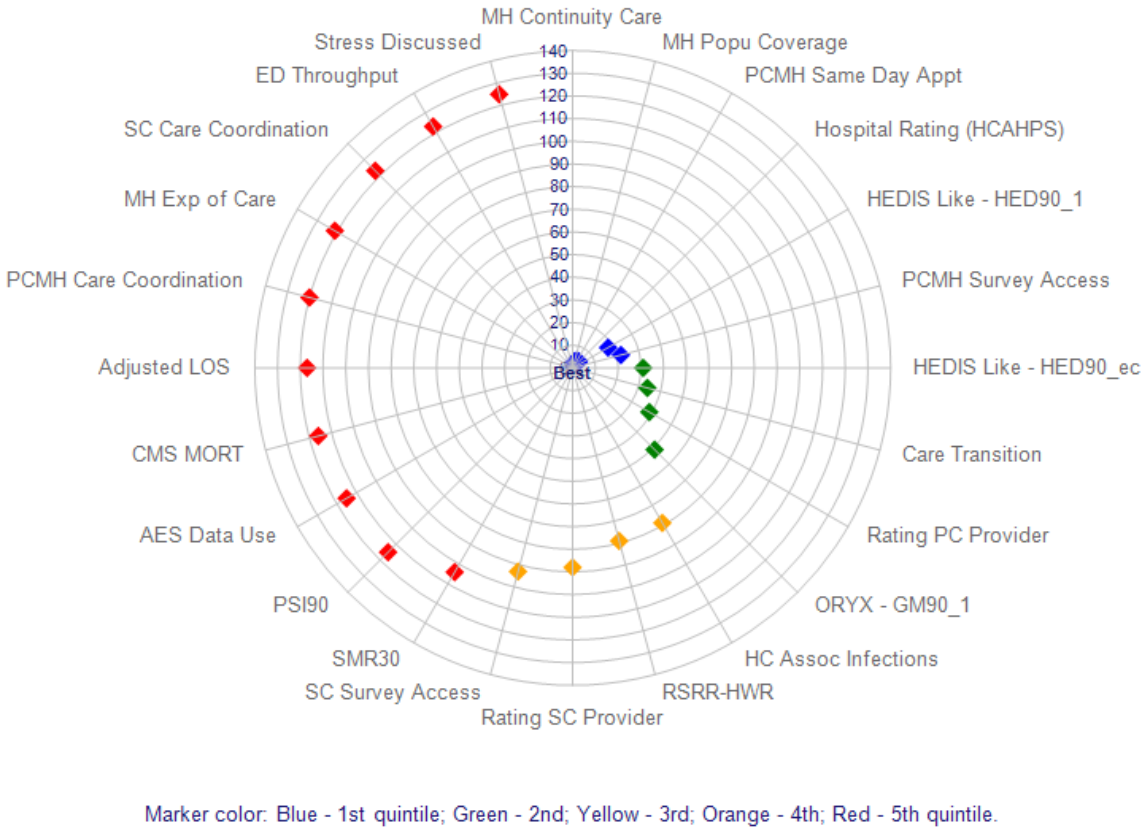

Figure 5. *System quality of care and efficiency metric rankings for FY 2020 quarter 4 (as of September 30, 2020).*

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."[37] The model "leverages much of the same data" used in the Centers for Medicare and Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[38]

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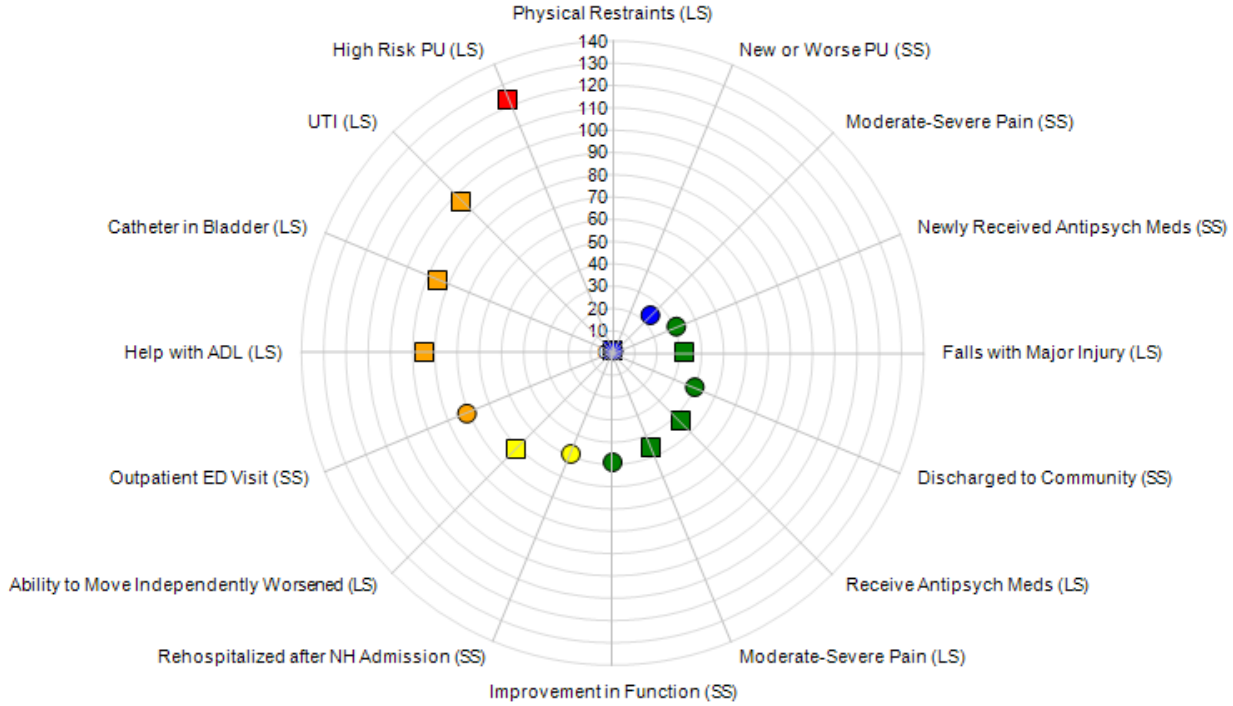
[37] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks*, July 16, 2021.

[38] 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."

Figure 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 Caribbean Healthcare System's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of new or worse pressure ulcer (PU)–short-stay (SS), falls with major injury–long-stay (LS), and improvement in function (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, outpatient ED visit (SS), urinary tract infections (UTI) (LS), and high risk PU (LS)).[39]



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

Figure 6. *VA Caribbean Healthcare System CLC quality measure rankings for 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.

Leadership and Organizational Risks Findings and Recommendations

At the time of OIG's virtual visit, the system's executive leadership team appeared stable. Since the current Chief of Staff served as the Deputy Chief of Staff for nearly five years prior to accepting this role, the leadership team had worked together for over two years.

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

A budget increase of over six percent in FY 2020 helped the healthcare system to ensure adequate staffing during the pandemic, enhance the system's ability to perform diagnostic studies, and increase specialty care services. The executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Selected employee satisfaction survey responses demonstrated general satisfaction with leaders and maintenance of an environment where staff felt respected and discrimination was not tolerated. However, the OIG noted opportunities for some leaders to reduce staff feelings of moral distress at work.

Patient experience survey data implied general satisfaction with care but highlighted opportunities for leaders to improve experiences for male and female veterans. Leaders reported efforts to address female veterans' experiences by recruiting a new care coordinator and increasing outreach activities.

Leaders spoke knowledgeably within their scope of responsibilities about improvement opportunities highlighted by SAIL and CLC SAIL measures and should continue to take actions to sustain and improve performance.

The OIG's review of the system's accreditation findings, sentinel events, and disclosures identified organizational risk factors. Although the Director was able to speak knowledgeably about improvement processes related to adverse events, the OIG identified concerns with the system's completion of institutional disclosures and the actions taken following serious adverse events.

VHA recognizes that the disclosure of harmful events is "consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence," and therefore, requires system leaders to inform or disclose to a patient or the patient's personal representative when a sentinel event occurs during the course of the "patient's care that resulted in, or is reasonably expected to result in, death or serious injury."[40] The OIG reviewed the system's 15 reported sentinel events from October 22, 2016, to March 22, 2021, and determined that 11 met the definition of a sentinel event and required institutional disclosures. Of those, seven had no evidence that staff conducted an institutional disclosure. The failure to perform an institutional disclosure can erode VA's core values and reduce patients' trust in the organization.

[40] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. "Serious injury may include significant or permanent disability, injury that leads to prolonged hospitalization, injury requiring life-sustaining intervention, or intervention to prevent impairment or damage, including, for example sentinel events as defined by The Joint Commission (see paragraph 13.q.). Such adverse events require institutional disclosure regardless of whether they resulted from an error." Since the OIG team reviewed some adverse events that occurred prior to the date of the current directive, the team also reviewed the directive that covered the time frame from October 22, 2016, through October 31, 2018. VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012, corrected version October 12, 2012. The OIG determined there were no changes in requirements.

For a root cause analysis to be credible, VHA requires the analyses to include identifying "at least one root cause with a corresponding action and outcome measure."[41] The healthcare system's reported 3 of 11 sentinel events with related root cause analyses did not have actions or associated outcome measures. This likely limited reviewers' ability to identify vulnerabilities and could have resulted in inadequate implementation of process improvements that could help prevent future patient harm events.

The acting Patient Safety Manager acknowledged the need to enhance the system's institutional disclosure and root cause analysis processes. The Director also recognized an opportunity to adopt a more agile method to connect the dots between a recommendation and its completion to ensure implementation of quality improvement processes.

Recommendation 1

1. The Director evaluates and determines any additional reasons for noncompliance and ensures staff conduct institutional disclosures for all applicable sentinel events.

Healthcare system concurred.

Target date for completion: October 1, 2021

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. Upon site visit, in March 2021, the VA Caribbean Healthcare System ascertain all sentinel events identified for each month have an institutional disclosure conducted per VHA Directive 1004.08. A Plan-Do-Study-Act (PDSA) was completed to strengthen the process of tracking institutional disclosures. All sentinel events will be tracked by the Patient Safety Program through the National Center for Patient Safety database and documented in a local tracking tool to ensure that Institutional disclosures are completed as required. Quality Management and Patient Safety staff have been re-oriented on the requirements of conducting institutional disclosures for all applicable sentinel events. The Chief of Quality will ascertain that monthly electronic health record reviews are completed to validate that all sentinel events have an institutional disclosure. Institutional disclosures will be monitored until a 90% level of compliance is achieved for two consecutive quarters then monthly monitoring for six consecutive months or two quarters to ensure sustained compliance. The compliance data will be reported quarterly to the Quality, Safety, and Value Committee.

[41] VHA Handbook 1050.01.

Recommendation 2

2. The Director evaluates and determines any additional reasons for noncompliance and ensures root cause analyses have actions and associated outcome measures.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. The Patient Safety team was reoriented on the importance of documenting outcome measures for all root cause analysis [RCA] actions. The Patient Safety Manager will ascertain monthly that all RCAs are reviewed to identify actions and associated outcome measures that are well designed. RCA actions and outcome measures will be monitored until a 90% level of compliance is achieved for two consecutive quarters then monthly monitoring for six consecutive months or two quarters to ensure sustained compliance. The compliance data will be reported monthly to the Quality, Safety, and Value Committee.

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.[42] 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.[43]

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."[44] "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."[45]

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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[42] "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.

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

[44] 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."

[45] 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.[46] 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.[47] 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."[48]

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."[49] 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."[50] 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

[46] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[47] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[48] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.
[49] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.
[50] VHA Directive 1026.01.

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[51] 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."[52] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[53] 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[54]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[55]
- 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."[56] 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

[51] 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."

[52] VHA Directive 1190.

[53] VHA Directive 1190.

[54] VHA Directive 1190.

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

[56] "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."[57] 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[58]

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.[59]

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 inconsistent member attendance at Surgical Workgroup meetings.

VHA requires medical facility directors to ensure that facilities have a surgical work group that meets monthly; this work group must be chaired by the Chief of Surgery and include the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[60] The OIG reviewed nine Surgical Workgroup meeting minutes from February through December 2020 and found that the Chief of Staff did not attend four (44 percent) and the Operating Room Nurse Manager did not attend seven (78 percent) meetings.[61] The lack of attendance by core members resulted in the review of surgery program activities without the perspectives of key staff. The Surgical Service Chief reported being unaware that the Chief of Staff and Operating Room Nurse Manager were required to attend meetings.

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

[58] VHA Directive 1102.01(1), *National Surgery Office,* April 4, 2019, amended May 22, 2019.

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

[60] VHA Directive 1102.01(1).

[61] The Surgical Workgroup did not hold meetings in April or May 2020 because elective surgical cases were suspended beginning in March 2020 due to the COVID-19 pandemic; therefore, there were nine required meetings during the review period.

Recommendation 3

3. The Director evaluates and determines any additional reasons for noncompliance and makes certain that core members regularly attend the Surgical Workgroup meetings.

Healthcare system concurred.

Target date for completion: October 30, 2021

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. Upon site visit, the VACHS [VA Caribbean Healthcare System] ascertain all members required by VHA Handbook 1102.01(1) or their representative, are present at all Surgical Workgroup meetings. Attendance will be taken and tracked for each meeting. Participant compliance will be tracked until a 90% rate is achieved for six consecutive months then monthly monitoring for six consecutive months or two quarters to ensure sustained compliance. Currently, there is a 100% level of compliance from May 2021 thru August 2021. The required members attendance will be reported monthly to the Quality, Safety, and Value Committee by the Chief of Surgery Service.

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."[62] 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."[63]

VA requires all RNs to hold at least one active, unencumbered license.[64] 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.[65] 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.[66] 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.[67]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 214 RNs hired from January 1, 2020, through February 15, 2021. The OIG determined whether

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

The OIG also reviewed credentialing files for 40 of the 214 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

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

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

[64] 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."

[65] 38 U.S.C. § 7402.

[66] VHA Directive 2012-030.

[67] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The OIG determined that all 214 RN licenses reviewed were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with primary source verification.

VHA requires all current and previously held licenses to be verified from primary sources prior to an individual's initial appointment or transfer from another medical facility.[68] The OIG found that 26 of 40 randomly selected RN credentialing files lacked evidence of primary source verification for each license held. Further, of the 14 RNs who had each license verified, none had licenses that were verified prior to appointment. This could lead to inappropriate hiring of nurses and subsequently affect the provision of quality care. The Human Resources Specialist and Human Resources Assistant cited a large influx of new hires, pressure to complete onboarding quickly, confusion regarding national guidance, and a lack of hiring processes for new employees during the COVID-19 pandemic as the reasons for noncompliance.

Recommendation 4

4. The Director evaluates and determines any additional reasons for noncompliance and ensures that credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. The Healthcare System realigned the process for Nursing credentialing from Human Resources to Credentialing and Privileging (C&P) Section following recommended staffing guidelines. The C&P Supervisor provided education to all C&P staff instructing them that the Commonwealth of Puerto Rico's state licensing board is up and running, therefore all license verifications have been purchased and VETPRO updated accordingly.

The C&P Supervisor conducts monthly audits to ensure each licensure for all newly selected Registered Nurses (RNs) were verified and have an appropriate verified license in the system. The target is a 90% level of compliance for two consecutive quarters then monthly monitoring for six consecutive months or two quarters to ensure sustained compliance. This process will be monitored in the Quality Safety and Value Committee.

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

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.[69] 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.[70]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[71] 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.[72]

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."[73] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[74]

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 51 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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[69] 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.

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

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

[72] 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.*

[73] 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.

[74] 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)[75]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[76]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The healthcare system generally met the requirements listed above. However, the OIG identified deficiencies with patient/caregiver education prior to administration of remdesivir.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare 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.[77]

For the 51 electronic health records reviewed, the OIG found that clinical staff did not

- provide the *Fact Sheet for Patients and Parents/Caregivers* to 55 percent of patients or caregivers before administering remdesivir,
- inform 25 percent of patients or caregivers that remdesivir was not an FDA-approved medication,
- inform 20 percent of patients or caregivers of the option to refuse remdesivir,
- inform 18 percent of patients or caregivers of the potential risks and benefits, and

[75] "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."

[76] "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.

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

- advise 96 percent of patients or caregivers of alternatives to receiving remdesivir prior to administration.

This could have resulted in patients and/or caregivers lacking the information needed to make a fully informed decision to receive medication. The Chief of Infectious Disease stated a belief that counseling was provided but not adequately documented in the medical record.

Given the FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.[78]

[78] Food and Drug Administration, "FDA News Release: FDA Approves 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.[79] 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.[80] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[81]

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 (EDs) 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.[82] 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 ED or urgent care center.[83] 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 EDs and urgent care centers, the OIG inspection team interviewed key employees and reviewed

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

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

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

[82] 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.

[83] 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.

- relevant documents;
- the electronic health records of 46 randomly selected patients who were seen in the ED from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[84]

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."[85] 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.[86]

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 32 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 generally met expectations with requirements for care coordination. However, the OIG noted deficiencies with transmission of patients' active medication lists and advance directives to receiving facilities and nurse-to-nurse communication between facilities.

VHA requires the Chief of Staff and ADPCS to ensure that transferring physicians or assigned designees "send all pertinent medical records available, including an active patient medication

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

[85] VHA Directive 1094.

[86] 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.

list…including documentation of the patient's advance directive made prior to transfer, if any" to the receiving facility.[87] The OIG estimated that for 28 percent of transfers, electronic health records lacked evidence that staff sent the patient's active medication list to the receiving facility.[88] In addition, the OIG determined that for the five patients with advance directives, physicians did not send a copy of the directives to the receiving facility. This could have resulted in incorrect treatment decisions and a lack of assurance that receiving facility staff could determine the patient's healthcare preferences should an urgent situation occur on arrival. The ED Chief reported that providers believed use of the national standardized template met the requirement. Further, the ED Chief stated that providers were unaware of how to locate advance directive information from other VHA medical facilities in the electronic health record. The OIG made no recommendation related to advance directives because of the small number of patients identified.

Recommendation 5

5. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure that transferring physicians or the assigned designees send active medication lists to the receiving facilities during inter-facility transfers.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff and Associate Director of Patient Care Services reviewed and determined that there were no additional reasons for noncompliance. An interdisciplinary team reviewed the transfer process at the VA Caribbean Healthcare System and developed a strategy to ensure required documentation is included in transfer documentation. The Bed Flow Coordinator is responsible for monitoring and evaluating all transfers to ensure compliance with VHA Directive 1094. The results of the ongoing monitoring will be reported to the Patient Flow Committee until a 90% level of compliance is met for six consecutive months then monthly monitoring for six consecutive months or two quarters to ensure sustained compliance.

VHA states that "the accepting physician, or designee, must speak directly with the referring physician, or designee, regarding the care of the patient. A nurse-to-nurse contact for a patient report is also essential. These verbal communications need to allow for questions and answers

[87] VHA Directive 1094.

[88] The OIG estimated that 95 percent of the time, the true compliance rate is between 55.5 and 87.1 percent, which is statistically significant below the 90 percent benchmark.

from both transferring and receiving facilities."[89] The OIG estimated that for 97 percent of transfers, electronic health records lacked evidence of nurse-to-nurse communication.[90] This could have resulted in staff at the receiving facility lacking the information needed to care for the patients. The ED Nurse Manager reported that a majority of receiving facilities in Puerto Rico lacked an assigned nurse for transfers, resulting in the inability to accomplish nurse-to-nurse communication. In addition, the Quality Management Nurse Consultant reported that staff temporarily assigned to the ED due to the COVID-19 pandemic lacked familiarity with the ED transfer process.

Recommendation 6

6. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that nurse-to-nurse communication occurs between sending and receiving facilities.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Associate Director of Patient Care Services (ADPCS) identified no additional reasons for noncompliance. To ensure compliance with nurse-to-nurse communication between sending and receiving facilities, the ADPCS initiated an action plan since April 2, 2021 with the following corrective actions: 100% of Emergency Department staff were reoriented on the completion of the Interdisciplinary Facility Note requirements; A checklist was implemented to ensure that Emergency Department nurses complete all the required documentation and provide the receiving facility with required transfer information for the veteran; A contact card with VACHS phone numbers and extensions was created to send to the receiving facility with the transfer documentation in the case that more information is needed; A daily audit of all interfacility transfer notes was initiated on 4/1/2021 to ensure compliance of interfacility transfer documentation and nurse-to nurse communication between sending and receiving facilities. This data will be monitored in the Patient Flow Committee quarterly and presented by the Chief Nurse of the Emergency Department until 90% level of compliance for 6 consecutive months is achieved then monthly monitoring for six consecutive months or two quarters to ensure sustained compliance.

[89] VHA Directive 1094.

[90] The OIG estimated that 95 percent of the time, the true compliance rate is between 0 and 10.4 percent, which is statistically significant 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."[91] 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."[92] 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[93]
- Establishment of a Disruptive Behavior Committee (DBC) or board that holds consistently attended meetings[94]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[95]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment (WBRA) with involvement from required participants[96]

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

[92] VHA Directive 2012-026.

[93] 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."

[94] 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."

[95] 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."

[96] 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 (PMDB) training within 90 days of hire. The WBRA 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.[97] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[98] 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 OIG determined that the healthcare system complied with some of the requirements for the management of disruptive and violent behavior. However, the OIG found deficiencies with the DBC members' attendance, documentation of patient notification of Orders of Behavioral Restriction, completion of the annual WBRA, and staff training.

VHA requires the Chief of Staff and Nurse Executive (ADPCS) to establish a DBC or board that includes a senior clinician chairperson; administrative support staff; the patient advocate; and representatives from the PMDB program, VA police, patient safety and/or risk management, and Union Safety Committee.[99]

The OIG found that from January through December 2020, the DBC met 11 times. Of those, the VA police and patient advocate did not attend two (18 percent) meetings, administrative support staff did not attend three (27 percent) meetings, and the patient safety and/or risk management representative did not attend four (36 percent) meetings.[100] This could have resulted in a lack of knowledge and expertise when assessing patients' disruptive behavior. The former DBC co-chair identified staff absences and retirement as the reasons for inconsistent attendance.

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

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

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

[100] VA Caribbean Healthcare System Center Memorandum No. 11-17-81, *Promotion of Peace, Prevention, and Management of Disruptive Behavior Committee*, July 2017. VA Caribbean Healthcare System locally named the Disruptive Behavior Committee (DBC) the Promotion of Peace and Prevention of Disruptive Behavior. The Former Disruptive Behavior Committee co-chair stated the committee did not meet in March 2020 due to the pandemic.

Recommendation 7

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

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff and Associate Director of Patient Care Services reviewed and determined that there were no additional reasons for noncompliance. The membership of the Disruptive Behavior Committee members was revised, seven (7) alternate members were identified and appointed to the committee. The attendance of all required members, as identified by VHA Directive, of the Disruptive Behavior Committee will be monitored until a 90% level of compliance is achieved for six consecutive months then monthly monitoring for six consecutive months or two quarters to ensure sustained compliance. The Chair of the committee will monitor required attendance compliance and report to the Accreditation Committee.

VHA requires the DBC to document patient notification of Orders of Behavioral Restriction, including the patient's right to appeal the order and the appeals process in the Disruptive Behavior Reporting System.[101] The OIG determined that staff notified patients for six Orders of Behavioral Restriction issued from January through December 2020. However, staff did not document patient notification for three Orders of Behavioral Restriction in the Disruptive Behavior Reporting System. This could have resulted in the DBC's inability to collect, communicate, and manage disruptive event information. The PMDB Training Coordinator reported believing the lack of documentation in the Disruptive Behavior Reporting System was due to inadequate staff oversight.

Recommendation 8

8. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain the Disruptive Behavior Committee documents patient notification of Orders of Behavioral Restriction in the Disruptive Behavior Reporting System.

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

Healthcare system concurred.

Target date for completion: October 1, 2021

Healthcare system response: The Chief of Staff evaluated the deficiency and identified no additional reasons for noncompliance. The Chair of the Disruptive Behavior Committee reinforced expectations for the use of the templated letter for Orders of Behavioral Restriction. The Disruptive Behavior Committee began to document patient notification of Orders of Behavioral Restriction in the Disruptive Behavior Reporting System in July 2021. The Chief of Psychology will review the monthly disruptive behavior events then review the electronic health record to determine if the patient was notified of the Order of Behavioral Restriction. Monthly audits will be completed until a 90% level of compliance is achieved for six consecutive months then monthly monitoring for six consecutive months or two quarters to ensure sustained compliance. Audit results will be reported quarterly to the Quality, Safety, and Value Committee.

VHA requires facilities to conduct a WBRA each fiscal year.[102] The WBRA is used to assign training levels based on the risk for exposure to disruptive behaviors and must be completed by an interdisciplinary team that includes the DBC chair, VA police, and a patient safety representative.[103] The DBC chair stated that the FY 2020 WBRA did not include participation by the DBC chair or a patient safety representative. This could have resulted in an incorrect assessment of the risk for exposure to disruptive behaviors and subsequent inadequate staff training or security precautions in areas at risk. The DBC chair reported believing that the former DBC co-chair's participation would be sufficient and that having at least 50 percent required participant attendance met the requirement.

Recommendation 9

9. The Director evaluates and determines any additional reasons for noncompliance and ensures the required interdisciplinary team conducts a Workplace Behavioral Risk Assessment each fiscal year.

[102] DUSHOM Memorandum, *Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum*, November 7, 2013.

[103] DUSHOM Memorandum, *Workplace Behavioral Risk Assessment (WBRA); DUSHOM Memorandum, Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*.

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. To ensure that all members of the interdisciplinary team participate in the Workplace Behavioral Risk Assessment (WBRA), the Chair of the Disruptive Behavior Committee re-oriented all required members of the mandatory participation requirement for the following fiscal years and will track participation accordingly. The Associate Chief of Staff for Behavioral Health Sciences will review the participation of the yearly risk assessment to determine if the activity needs to be reconvened. 90%-member participation compliance is expected of the next Workplace Behavioral Risk Assessment, outcome will be reported to the Quality, Safety, and Value Committee.

VHA requires that staff are assigned part 1 of the PMDB training when hired and additional levels of training based on the risk level assigned to their work area.[104] The OIG found that 4 of 30 (13 percent) selected staff did not complete the required training based on their work area's risk level. This could have resulted in lack of awareness, preparedness, and precautions when responding to disruptive behavior. The PMDB Training Coordinator stated that a lack of trainers, coupled with space restrictions due to COVID-19 pandemic precautions, resulted in reduced training opportunities.

Recommendation 10

10. The Director evaluates and determines any additional reasons for noncompliance and ensures that staff complete the required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[105]

[104] DUSHOM Memorandum, *Update to Prevention Management of Disruptive Behavior (PMDB) Training Assignments.*

[105] 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: April 1, 2022

Healthcare system response: The VACHS partially resumed face-to-face PMDB trainings in August 2020. PMDB Part 1 Training has been offered consistently online through TMS [Talent Management System]. Compliance with PMDB Part 1 online training has been monitored weekly since February 2021. PMDB Part 2 for Staff in Mod/High Risk was resumed in June 2021 and has been offered as a face-to-face course consistently since then. VACHS is working towards including PMDB Part 2 Mod/High Risk training as part of the NEO [New Employee Orientation] to comply with VHA Directive 5019.01 (8/23/2021). The PMDB Part 3 Training has yet to be resumed for front line staff. To meet the PMDB training demands for Part 2 and Part 3, two Train the Trainer programs were requested and approved by the National PMDB Program Office during FY21. The PMDB Coordinator continues to identify and assign required trainings to new employees as they integrate into their workstations. PMDB training compliance will be monitored by the PMDB Coordinator program until a 90% level of compliance is achieved for six consecutive months then monthly monitoring for six consecutive months or two quarters to ensure sustained compliance. A deficiency report will be generated monthly and shared with service chiefs and discussed in the Accreditation Committee.

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 10 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 10 OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and ADPCS. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address system's 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)	• Staff conduct institutional disclosures for all applicable sentinel events. • Staff ensure root cause analyses have actions and associated outcome measures.	• 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	• Core members regularly attend the Surgical Workgroup meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• Credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.	• 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	• None

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	• Transferring physicians or the assigned designees send active medication lists to the receiving facilities during inter-facility transfers. • Nurse-to-nurse communication occurs between sending and receiving facilities.	• None
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	• The Disruptive Behavior Committee documents patient notification of Orders of Behavioral Restriction in the Disruptive Behavior Reporting System.	• Required members attend Disruptive Behavior Committee meetings. • Required interdisciplinary team conducts a Workplace Behavioral Risk Assessment each fiscal year. • 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 8.[1]

Table B.1. Profile for VA Caribbean Healthcare System (672) (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	$710,479,755	$661,583,926	$705,199,825
Number of:			
• Unique patients	61,682	60,912	58,879
• Outpatient visits	906,786	990,460	990,559
• Unique employees§	3,237	3,324	3,519
Type and number of operating beds:			
• Blind rehab	12	12	12
• Community living center	122	122	122
• Medicine	158	158	158
• Mental health	30	30	30
• Rehabilitation medicine	20	20	20
• Spinal cord	20	20	20
• Surgery	40	40	40
Average daily census:			
• Blind rehab	6	6	2
• Community living center	90	88	71
• Domiciliary	0	–	–
• Medicine	132	115	104
• Mental health	27	28	21
• Rehabilitation medicine	13	12	10

[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 healthcare systems 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‡
• Spinal cord	15	16	12
• Surgery	16	12	10

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
Ponce, PR	672B0	19,194	11,182	Anesthesia Cardiology Dermatology Endocrinology Eye General surgery Nephrology Otolaryngology Podiatry Poly-Trauma	EKG EMG Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Prosthetics Weight management

[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
Ponce, PR (continued)				Pulmonary/ Respiratory disease Rehab physician Urology		
Mayaguez, PR	672BZ	21,490	9,327	Allergy Anesthesia Cardiology Dermatology Endocrinology Eye Nephrology Podiatry Poly-Trauma Pulmonary/ Respiratory disease Rehab physician Spinal cord injury Urology	EMG Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Prosthetics Social work Weight management
Saint Croix, VI	672GA	1,444	100	Cardiology Rehab physician	EKG Laboratory & Pathology	Nutrition
Saint Thomas, VI	672GB	1,554	44	Cardiology Rehab physician	Laboratory & Pathology	Nutrition Pharmacy
Arecibo, PR	672GC	8,500	2,765	Dermatology Pulmonary/ Respiratory disease Rehab physician	Laboratory & Pathology	Nutrition Pharmacy Social work

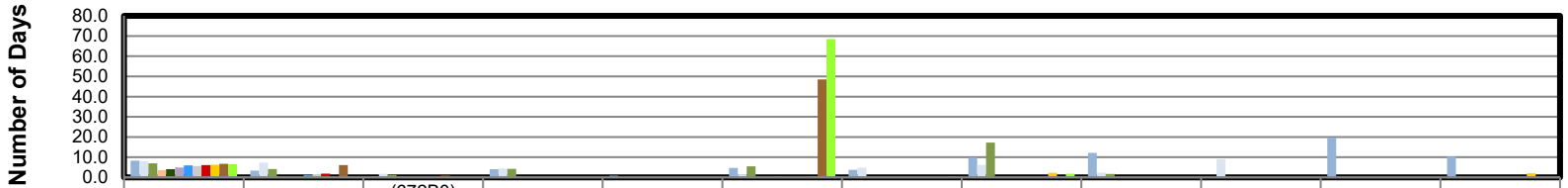
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Pueblo Ward, PR	672GD	7,406	1,014	Dermatology Rehab physician	Laboratory & Pathology	Nutrition Pharmacy
Guayama, PR	672GE	3,621	2,388	Dermatology Pulmonary/ Respiratory disease Rehab physician	Laboratory & Pathology	Nutrition Pharmacy
Comerio, PR	672QA	823	–	–	Radiology	Nutrition Social work
Utuado, PR	672QB	424	–	Rheumatology	–	Nutrition Social work
Vieques, PR	672QC	321	2	–	–	Nutrition

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



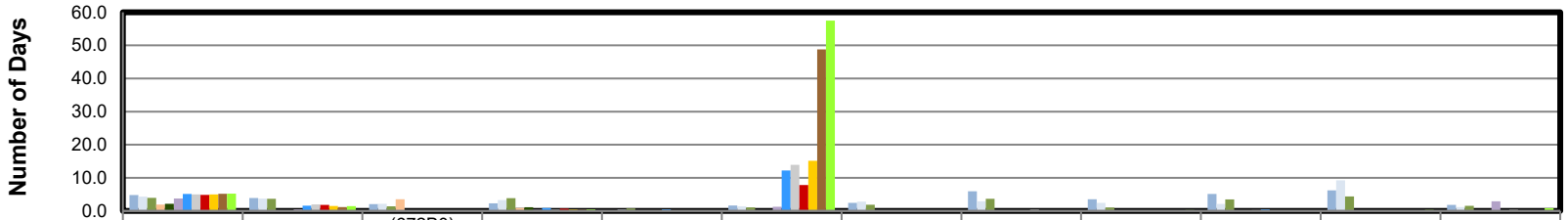
	VHA All	(672) San Juan, PR	(672B0) Ponce, PR (Eurípides Rubio)	(672BZ) Mayaguez, PR	(672GA) Saint Croix, VI	(672GB) Saint Thomas, VI	(672GC) Arecibo, PR	(672GD) Ceiba, PR	(672GE) Guayama, PR	(672QA) Comerio, PR	(672QB) Utuado, PR	(672QC) Vieques, PR
JAN-FY19	8.3	3.3	0.5	4.0	0.8	4.7	3.8	9.8	12.1	n/a	19.7	10.3
FEB-FY19	8.1	7.3	1.8	4.4	0.0	1.6	4.8	6.1	2.3	9.0	0.0	n/a
MAR-FY19	6.9	4.1	1.2	4.2	0.0	5.5	0.0	17.3	1.7	n/a	0.0	0.0
APR-FY19	3.6	0.2	0.0	0.0	n/a	n/a	0.0	0.0	n/a	n/a	n/a	n/a
MAY-FY19	4.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	n/a	n/a	n/a	n/a
JUN-FY19	4.9	0.1	0.0	0.0	0.0	0.4	0.0	0.0	0.0	n/a	0.0	n/a
JUL-FY19	5.9	1.3	0.0	0.0	0.0	0.0	0.0	0.0	n/a	n/a	n/a	n/a
AUG-FY19	5.6	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	n/a	n/a	n/a
SEP-FY19	6.1	1.8	1.1	0.0	0.0	0.1	0.0	0.4	0.0	0.0	n/a	n/a
OCT-FY20	6.3	0.1	0.0	0.0	0.0	0.3	0.0	2.3	0.0	0.0	n/a	2.0
NOV-FY20	6.7	6.1	0.0	0.0	0.0	48.5	0.0	0.0	0.0	0.0	n/a	0.0
DEC-FY20	6.6	0.2	0.1	0.0	0.0	68.5	0.4	1.8	0.0	n/a	0.0	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 has on file the healthcare system's explanation for the increased wait times for (672GB) Saint Thomas, VI.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA All	(672) San Juan, PR	(672B0) Ponce, PR (Eurípides Rubio)	(672BZ) Mayaguez, PR	(672GA) Saint Croix, VI	(672GB) Saint Thomas, VI	(672GC) Arecibo, PR	(672GD) Ceiba, PR	(672GE) Guayama, PR	(672QA) Comerio, PR	(672QB) Utuado, PR	(672QC) Vieques, PR
JAN-FY20	4.8	3.9	2.1	2.3	0.2	1.6	2.4	5.9	3.5	5.1	6.2	1.8
FEB-FY20	4.3	3.7	2.1	3.3	0.4	1.4	2.8	2.9	2.4	2.1	9.2	1.2
MAR-FY20	3.9	3.7	1.4	3.9	0.7	1.1	1.8	3.7	1.0	3.5	4.4	1.5
APR-FY20	1.9	0.2	3.5	0.9	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0
MAY-FY20	2.1	0.2	0.0	1.1	0.0	0.0	0.0	0.0	0.0	n/a	0.0	0.0
JUN-FY20	3.7	0.5	0.1	0.3	0.1	1.3	0.0	0.0	0.1	0.3	0.0	2.9
JUL-FY20	5.1	1.6	0.1	0.9	0.5	12.2	0.1	0.2	0.0	0.5	0.0	0.0
AUG-FY20	5.0	2.0	0.1	0.4	0.1	13.9	0.0	0.4	0.0	0.0	0.0	0.4
SEP-FY20	4.9	1.8	0.1	0.7	0.0	7.8	0.0	0.2	0.1	0.0	0.0	0.0
OCT-FY21	5.0	1.5	0.1	0.5	0.0	15.1	0.0	0.0	0.0	0.0	0.0	0.0
NOV-FY21	5.2	1.2	0.1	0.4	0.1	48.8	0.1	0.2	0.0	0.1	0.0	0.1
DEC-FY21	5.2	1.5	0.2	0.5	0.0	57.5	0.2	0.0	0.2	0.2	0.3	0.8

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the healthcare system's explanation for the increased wait times for (672GB) Saint Thomas, VI.

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." The absence of reported data is indicated by "n/a."

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
Hospital Rating (HCAHPS)	Overall rating of hospital stay (inpatient only)	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

Measure	Definition	Desired Direction
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
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 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: September 17, 2021

From: Director, Sunshine Healthcare Network (10N8)

Subj: Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico

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

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

I have reviewed the VAOIG's report as well as the VA Caribbean Healthcare System's response and concur with the findings, recommendations, and action plans submitted by the VA Caribbean, San Juan, Puerto Rico.

(Original signed by:)

Miguel H. LaPuz, M.D., MBA
Network Director, VISN 8

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: September 14, 2021

From: Director, VA Caribbean Healthcare System (672/00)

Subj: Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico

To: Director, Sunshine Healthcare Network (10N8)

1. I have reviewed the findings within the Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System. The VACHS concurs with the outcome of the inspection and recommendations provided. The corrective action plan and target dates have been established and I have complete confidence that the plans will be effective.

2. Thank you for the opportunity to respond to this report and strengthen the care of our Veterans.

(Original signed by:)

Carlos E. Escobar, BED-Arch, MSHP, FACHE
Executive Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Megan Magee, MSN, RN, Team Leader Tasha Felton Williams, DNP, ACNP Debra Naranjo, DNP, RN Rhonda Omslaer, JD, RN Cheryl Walsh, MS, RN
Other Contributors	Daisy Arugay-Rittenberg, MT Elizabeth Bullock Shirley Carlile, BA Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH, BS Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Scott McGrath, BS Larry Ross, Jr., MS Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH, BS Robert Wallace, ScD, MPH

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