DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 1: VA New England Healthcare System in Bedford, Massachusetts

CHIP REPORT | REPORT #21-00235-13 | NOVEMBER 18, 2021

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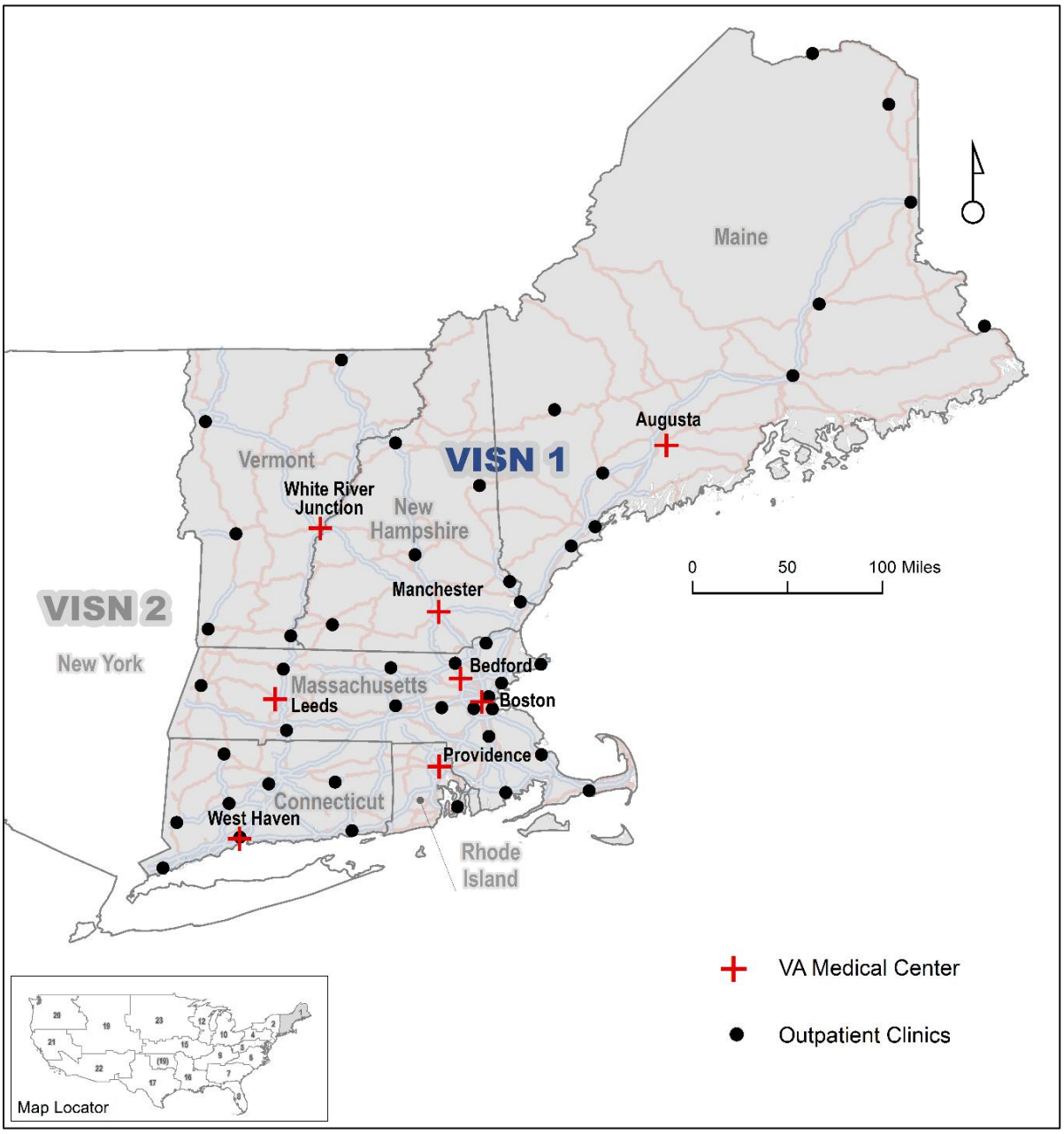

Figure 1. *Veterans Integrated Service Network 1: VA New England Healthcare System.*
Source: Veterans Affairs Site Tracking (VAST) Database (accessed March 16, 2021).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
FTE	full-time equivalent
FY	fiscal year
HCS	healthcare system
OIG	Office of Inspector General
QMO	quality management officer
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by Veterans Integrated Service Network (VISN) 1: VA New England Healthcare System. The inspection covers key clinical and administrative processes 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 OIG selects and evaluates specific areas of focus each year.

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

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Medical staff credentialing
4. Environment of care
5. Mental health (focusing on suicide prevention)
6. Care coordination (targeting inter-facility transfers)
7. Women's health (examining comprehensive care)

The OIG conducted this unannounced virtual review during the week of February 1, 2021. The OIG also performed virtual reviews of the following VISN 1 facilities during the weeks of January 25 and February 1, 2021:

- Edith Nourse Rogers Memorial Veterans Hospital (Bedford, Massachusetts)
- Manchester VA Medical Center (New Hampshire)
- Providence VA Medical Center (Rhode Island)
- VA Boston Healthcare System (Massachusetts)
- VA Central Western Massachusetts Healthcare System (Leeds)
- VA Connecticut Healthcare System (West Haven)
- VA Maine Healthcare System (Augusta)

[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)."

- White River Junction VA Medical Center (Vermont)

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. The findings presented in this report are a snapshot of VISN 1 and facility performance within the identified focus areas at the time of the OIG review. The findings in this report may help VISN leaders identify areas of vulnerability 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 five recommendations to the Network Director and Chief Medical Officer (CMO). These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the VISN leadership team consisted of the Network Director, Deputy Network Director, CMO, and Quality Management Officer. The VISN managed organizational communication and accountability through a committee reporting structure with its Executive Leadership Council overseeing the Organizational Health; Healthcare Delivery; Quality, Safety and Value; and Healthcare Operations Committees.

When the team conducted this review, the executive leaders, except the CMO, had worked together since 2018. The CMO position had been vacant since October 2020 and the Deputy CMO filled the role in an acting capacity. The Deputy Network Director, assigned to the VISN in 2015, was the longest-serving executive leader. The Quality Management Officer and Network Director were assigned in 2017 and 2018, respectively.

The OIG reviewed selected employee satisfaction and patient experience survey results. The OIG concluded that VISN leaders were engaged and promoted a culture of safety where employees felt safe bringing forward issues and concerns. The selected patient experience survey scores were higher than Veterans Health Administration (VHA) averages and indicated that patients were generally satisfied with the care provided.

The inspection team also evaluated VISN access metrics and clinical vacancies. The team identified potential organizational risks at select facilities, with wait times over 20 days and clinical vacancies in certain specialties.

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."[2]

[2] "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.)

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.[3]

The leadership team was knowledgeable within their scope of responsibilities about selected SAIL and community living center SAIL measures. However, the OIG identified that the Network Director, CMO, and Quality Management Officer had opportunities to improve their oversight of facility-level quality, safety, and value; care coordination; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 1 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

Medical Staff Credentialing

The OIG found that one physician had a potentially disqualifying licensure action that required further documented review.

Mental Health

The OIG observed compliance with involvement of a mental health professional in the VISN's primary governing body. However, the OIG found deficiencies with the designation of a mental health professional to serve on each state's suicide prevention council or workgroup.

Women's Health

The OIG found general compliance with the appointment of a lead women veterans program manager, completion of annual site visits, and analysis of access and satisfaction data. However, the OIG found deficiencies with quarterly program updates to VISN leaders, staff education gap analyses, and VISN-level support staff availability.

Conclusion

The OIG conducted a detailed inspection across eight key areas and subsequently issued five recommendations for improvement to the Network Director and CMO. The number of recommendations should not be used as a gauge for the overall quality of care provided within this VISN. The intent is for VISN leaders to use these recommendations to help guide

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

improvements in operations and clinical care throughout the network of assigned facilities. The recommendations address issues that may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix G, page 50, and the responses within the body of the report for the full text of the Network Director's comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 1: VA New England Healthcare System. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so informed decisions can be made to improve care.

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.[1] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[2]

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review and initiated a 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:[3]

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[4]
3. Quality, safety, and value (QSV)
4. Medical staff credentialing
5. Environment of care
6. Mental health (focusing on suicide prevention)
7. Care coordination (targeting inter-facility transfers)
8. Women's health (examining comprehensive care)

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[1] 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.

[2] 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.

[3] 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.

[4] "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)."

Methodology

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

The inspection examined operations from December 5, 2016, through February 5, 2021, the last day of the unannounced week-long virtual review.[5]

The OIG also performed inspections of the following VISN 1 facilities during the weeks of January 25 and February 1, 2021:

- Edith Nourse Rogers Memorial Veterans Hospital (Bedford, Massachusetts)
- Manchester VA Medical Center (VAMC) (New Hampshire)
- Providence VAMC (Rhode Island)
- VA Boston Healthcare System (HCS) (Massachusetts)
- VA Central Western Massachusetts HCS (Leeds)
- VA Connecticut HCS (West Haven)
- VA Maine HCS (Augusta)
- White River Junction VAMC (Vermont)

The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 1 jurisdiction 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.[6] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VISN leaders complete corrective actions. The Network Director's responses to the report recommendations appear

[5] The range represents the time from the last Clinical Assessment Program review of the White River Junction VAMC to the completion of the unannounced week-long virtual CHIP visit in February 2021 (see appendix D).

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

within each topic area. The OIG accepted the action plans that VISN 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.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can affect the ability to provide care in the clinical focus areas.[7] To assess this VISN's risks, the OIG considered the following indicators:

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

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility virtual CHIP visits performed during the weeks of January 25 and February 1, 2021.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the veterans' healthcare system.[8]

VISN 1 covers 6 New England states and oversees 8 VAMCs and HCSs and 49 community-based outpatient clinics. According to data from the VA National Center for Veterans Analysis and Statistics, VISN 1 had a veteran population of 795,428 at the end of fiscal year (FY) 2020 and a projected population of 769,490 by the end of FY 2021. The VISN's FY 2020 medical care

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

[8] *The Curious Case of the VISN Takeover: Assessing VA's Governance Structure, Hearing Before the House Committee on Veterans' Affairs*, 115th Cong. (2018) (statement of Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration).

budget of $3,673,147,632 represented an increase of approximately 14 percent from the previous FY.

The VISN had high performance and quality scores, strong research and education programs, affiliations with highly rated medical schools, and several VA Clinical Programs of Excellence. However, the VISN has aging infrastructure and lack of space. Of nearly 390 buildings, 175 are historic or eligible for the National Register of Historic Places. VISN leaders reported the infrastructure as a critical area of need for additional support and resources.

VISN 1 had an executive leadership team consisting of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), and Quality Management Officer (QMO). The CMO and QMO oversaw facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.[9]

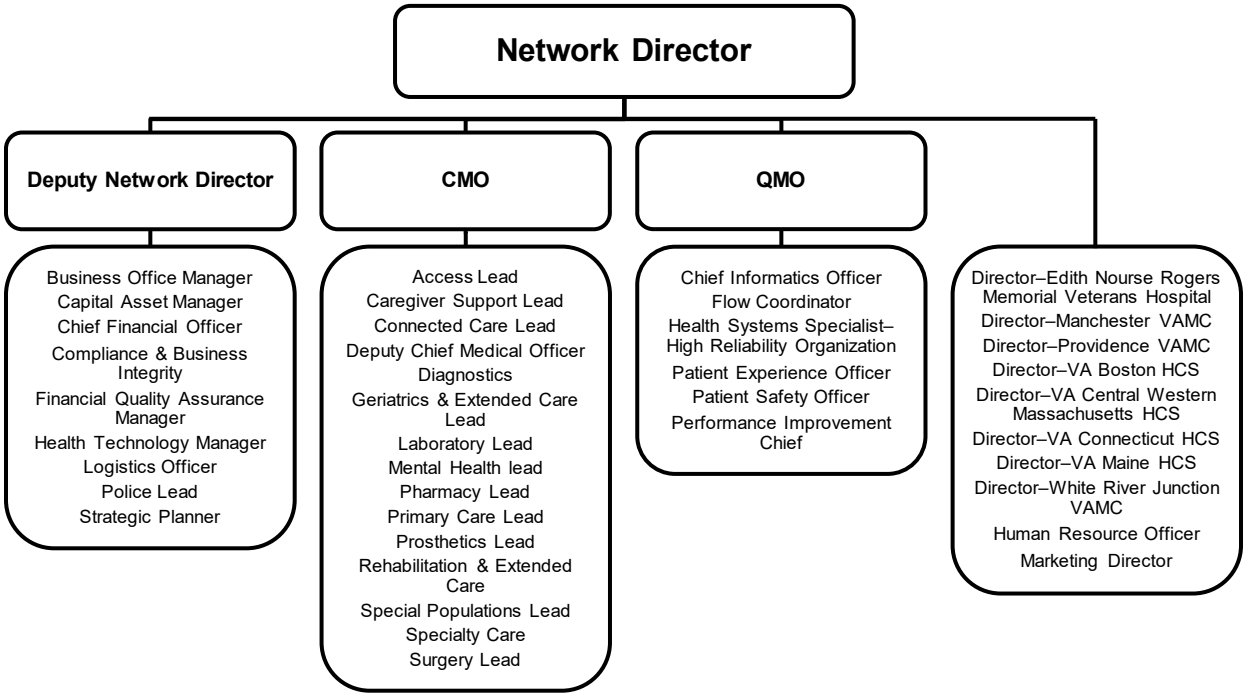


Figure 2. *VISN 1 organizational chart.*
Source: VA New England Healthcare System (received February 1, 2021).

At the time of the OIG virtual review, the executive leaders, except for the CMO, had worked together since 2018. The CMO position had been vacant since October 2020. The Deputy CMO, assigned in 2017, filled the CMO role in an acting capacity. The Deputy Network Director,

[9] For this VISN, the Network Director is responsible for the directors of the Edith Nourse Rogers Memorial Veterans Hospital, Manchester VAMC, Providence VAMC, VA Boston HCS, VA Central Western Massachusetts HCS, VA Connecticut HCS, VA Maine HCS, and White River Junction VAMC.

assigned to the VISN in 2015, was the longest-serving member of the executive leadership team. The QMO and Network Director were assigned in 2017 and 2018, respectively (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	September 1, 2018
Deputy Network Director	December 13, 2015
Chief Medical Officer	October 3, 2020 (acting)
Quality Management Officer	February 19, 2017

Source: VA New England Healthcare System (received February 1, 2020).

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

The executive leaders were generally knowledgeable within their scopes of responsibility about VHA data and/or factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. Leaders also had a sound understanding of Community Living Center (CLC) SAIL metrics. In individual interviews, the executive leaders spoke knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. Details regarding these actions are below.

The leaders were members of the VISN's Executive Leadership Council, which was responsible for processes that enhance network performance by

- providing organizational values and strategic direction,
- developing policy and making decisions,
- managing compliance and financial performance,
- reviewing organizational performance and capabilities,
- identifying priorities for improvement and opportunities for innovation, and
- developing and communicating organizational goals and objectives across the network.

The Network Director served as the chairperson of the Executive Leadership Council, which had direct oversight of the Organizational Health, Healthcare Delivery, QSV, and Healthcare Operations Committees (see figure 3).

Figure 3. *VISN 1 committee reporting structure.*
Source: VA New England Healthcare System (received February 1, 2021).

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[10] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[11] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on VISN leaders.

To assess employee attitudes toward VISN leaders, the OIG reviewed VHA All Employee Survey satisfaction results from October 1, 2019, through September 30, 2020.[12] Table 2 summarizes those results. Selected VISN scores for employee satisfaction and attitudes toward leaders were notably better than VHA averages. Leaders reported sharing employee satisfaction results with VISN-level staff. They emphasized validation of staff opinions, promotion of transparency, and deliberate steps to improve trust.[13]

[10] "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.)

[11] "AES Survey History."

[12] Ratings are based on responses by employees who report to or are aligned under the Network Director, Deputy Network Director, CMO, and QMO.

[13] 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. The All Employee Survey results are not fully reflective of employee satisfaction with the acting CMO, who was not in the role when the survey was administered.

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

Questions/Survey Items	Scoring	VHA Average	VISN 1 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	78.9	94.2	90.0	96.0	93.0
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	3.7	4.8	4.3	4.2	4.5
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.9	4.7	4.7	4.3	4.6
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	4.6	4.7	4.3	4.6

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

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The leaders' averages were notably better than the VHA averages. Overall, VISN leaders appeared to maintain an environment where employees felt safe bringing forth issues and concerns.

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

Questions/Survey Items	Scoring	VHA Average	VISN 1 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.1	4.6	4.9	4.0	4.7
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	4.0	4.6	4.9	4.0	4.6
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day) lower is better.	1.4	1.3	1.0	0.4	1.0	0.5

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

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[14] 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.[15]

[14] "Stand Up to Stop Harassment Now! White Ribbon VA," 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.

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

Table 4 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. Again, the leaders' averages were notably higher than the VHA averages. Leaders appeared to promote an environment where discrimination was not tolerated, and staff felt safe bringing up problems and tough issues.

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

Questions/Survey Items	Scoring	VHA Average	VISN 1 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.2	4.5	4.7	4.8	4.6
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.3	4.7	4.9	4.8	4.7
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.1	4.6	4.6	4.6	4.8

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

Patient Experience

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and support benchmarking its performance against the private sector. VHA collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys.

To assess patient attitudes toward their healthcare experiences, the OIG reviewed patient experience survey responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences from October 1, 2019, through September 30, 2020. Table 5 provides relevant survey results for VHA and VISN 1.[16] The VISN averages for the selected survey questions were higher than VHA averages. VISN 1 patients appeared more satisfied with their care than VHA patients in general.

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

VISN 1 facility scores for the selected survey questions are in appendix C. VISN leaders reported that the Veteran Experience Office tracked patient satisfaction scores and leaders designated performance improvement in veteran experience as a strategic objective for FY 2021, with special emphasis on creating an exceptional patient experience even with COVID-19 pandemic restrictions.

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

Questions	Scoring	VHA Average	VISN 1 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	75.2
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 "Agree" and "Strongly Agree" responses.	82.5	88.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.8	89.9

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

Access to Care

A VA priority is achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans. VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[17] VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics

[17] VHA Directive 1230(3), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 7, 2021. The "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

based on appointment creation and patient preferred dates.[18] Wait time measures based on "create date" have the advantage of not relying on the accuracy of the "preferred date" entered into the scheduling system and are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, and includes a "clinically indicated date." The disadvantage to "create date" metrics is that wait times do not account for specific patient requests or availability. Wait time measures based on patient preferred dates consider patient preferences but rely on appointment schedulers accurately recording the patients' wishes into the scheduling software.[19]

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, they became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[20] However, with the passage of the VA MISSION Act of 2018 on June 6, 2018, and subsequent enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[21]

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

To examine access to primary and mental health care within VISN 1, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 6 and 7 provide wait time statistics for

[18] "Completed appointments cube data definitions," VA Business Intelligence Office, accessed March 28, 2019, https://bioffice.pa.cdw.va.gov/. (This is an internal VA website not publicly accessible.)

[19] Office of Veterans Access to Care, *Specialty Care Roadmap*, November 27, 2017.

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

[21] VA MISSION Act of 2018, Pub. L. No. 115-182, Stat. 1393; VA Office of Public Affairs Media Relations, *Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018,* April 2019.

completed primary care and mental health appointments from October 1 through December 31, 2020.[22]

Table 6. Primary Care Appointment Wait Times (October 1, 2020, through December 31, 2020)

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VISN 1	2,628	18.0
Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA)	179	12.3
Manchester VAMC (NH)	220	21.5
Providence VAMC (RI)	446	25.0
VA Boston HCS (MA)	657	15.8
VA Central Western Massachusetts HCS (Leeds)	198	13.3
VA Connecticut HCS (West Haven)	328	10.4
VA Maine HCS (Augusta)	422	19.8
White River Junction VAMC (VT)	178	17.3

Source: VHA Support Service Center (accessed January 4, 2021).

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

[22] Reported primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine, and records visits for comprehensive primary care services. Reported mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual, and records visits for the evaluation, consultation, and/or treatment by staff trained in mental diseases and disorders.

Table 7. Mental Health Appointment Wait Times (October 1 through December 31, 2020)

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VISN 1	829	11.5
Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA)	96	6.8
Manchester VAMC (NH)	42	10.4
Providence VAMC (RI)	121	12.9
VA Boston HCS (MA)	207	9.6
VA Central Western Massachusetts HCS (Leeds)	121	15.0
VA Connecticut HCS (West Haven)	102	9.5
VA Maine HCS (Augusta)	116	15.7
White River Junction VAMC (VT)	24	10.5

Source: VHA Support Service Center (accessed January 4, 2021).

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

Based on wait times alone, the MISSION Act may improve access to primary care for patients in the Manchester and Providence VAMCs, where the average wait times for new primary care appointments were 21.5 and 25.0 days, respectively. Nonetheless, the OIG noted that these wait times highlight opportunities for these two facilities to improve the timeliness of primary care provided "in house" and decrease the potential for fragmented care among patients referred to community providers.

Executive leaders regularly tracked wait times in the VISN's Monthly Management Report, which displays current data for each VAMC or HCS and assigned community-based outpatient clinic. Leaders explained that higher wait times in the Manchester and Providence VAMCs may have been associated with past vacancies in Primary Care Service Line leadership positions and the shifting of community-based outpatient clinic staff to provide inpatient COVID-19 pandemic support.

To improve access to care, the VISN staffed a clinical resource hub at the VA Connecticut HCS to provide gap coverage across facilities within the VISN. Since the start of FY 2020, the clinical resource hub's scope of work and size of staff has increased to over 32 full-time equivalent (FTE) employees. Leaders reported proposed funding to hire about 61 additional FTE employees, which included approximately 5 for mental health and 7 for primary care. For FY 2020, the VISN's goal was to increase the percentage of veterans using telehealth to 15.0 percent. The VISN exceeded that goal, achieving a 22.7 percent usage rate.

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover—or instability—and high clinical vacancy rates negatively affect access to care, quality, patient safety, and patient and staff satisfaction. Turnover can directly affect staffing levels and further reduce employee and organizational performance through the loss of experienced staff.[23]

To assess the extent of clinical vacancies across VISN 1 facilities, the OIG held discussions with the Acting Human Resource Officer and reviewed the total number of vacancies by facility, position, service or section, and FTE employees. Table 8 provides the vacancy rates across the VISN as of February 1, 2021.

Table 8. Reported Vacancy Rates for VISN 1 Facilities (as of February 1, 2021)

Facility	Clinical Vacancies	Clinical Vacancy Rate (%)	Total Vacancy Rate (%)
Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA)	11	10.1	11.9
Manchester VAMC (NH)	31	16.6	13.4
Providence VAMC (RI)	22	11.7	13.1
VA Boston HCS (MA)	81	14.4	8.3
VA Central Western Massachusetts HCS (Leeds)	17	9.6	9.2
VA Connecticut HCS (West Haven)	19	9.3	16.8
VA Maine HCS (Augusta)	29	16.6	19.3
White River Junction VAMC (VT)	33	19.4	21.3

Source: VISN 1: VA New England Healthcare System Deputy Human Resources Officer (received February 1, 2021).

The OIG found the following primary care clinical vacancies across VISN 1:

- Physicians: 34
- Physician assistants: 5
- Nurse practitioners: 18
- Nurses: 52

Clinical staffing may be a contributing factor in primary care wait time challenges at the Manchester and Providence VAMCs. The Manchester VAMC had four physician, one physician

[23] James Buchanan, "Reviewing the Benefits of Health Workforce Stability," *Human Resources for Health* 8, no. 29 (December 2010).

assistant, and two nurse practitioner FTE vacancies. The Providence VAMC had five physician and two nurse practitioner FTE vacancies.

For mental health, the OIG found the following clinical vacancies across VISN 1:

- Psychiatrists: 23
- Psychologists: 30
- Nurses: 22
- Social workers: 57

The VISN's average wait time for new mental health patients was 11.5 days. The longest wait times were at the VA Maine HCS (15.7 days) and VA Central Western Massachusetts HCS (15.0 days). Clinical staffing may be contributing to the longer wait times at the VA Maine HCS, where two psychiatrist, four psychologist, and eight social worker FTE positions were vacant.

The Acting Human Resource Officer reported holding regular meetings with executive leaders to review progress on hiring new staff for existing vacancies, review the "time to hire" report, and track timeliness of human resource actions. The Acting Human Resource Officer also reported recruiting challenges in rural areas and salary competition with private sector and university affiliates in metropolitan areas. The VISN provided incentives like VA's Education Debt Reduction Program and recruitment and relocation bonuses.[24] In FY 2020, the VISN spent $3,240,231 on Education Debt Reduction Program incentives. Also, the VISN used VA's rapid hiring processes to increase facility staffing levels during the COVID-19 pandemic. The VISN onboarded 550 staff between March 1, 2020, and the time of the virtual review.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. At the time of the virtual review, 42 recommendations remained open; however, as of October 2021, VISN and facility leaders closed all but 7 recommendations for improvement listed in appendix D.[25] The 7 open recommendations were from reports published in 2019 and 2020.

[24] Department of Veterans Affairs, *Education Debt Reduction Program (EDRP)*, accessed March 11, 2020, https://www.vacareers.va.gov/Content/Documents/Print/EDRP_VA_Careers_Page.pdf. Education Debt Reduction Program (EDRP) authorizes VA to provide student loan reimbursement to employees with qualifying loans who are in difficult to recruit and retain direct patient care positions. Loans must be for the health professional's education that qualified the applicant for a specific position. Each Veterans Health Administration facility determines which positions are hard to recruit and retain and when the facility will offer EDRP for these positions. EDRP is a recruitment and retention incentive only offered or approved for certain positions.

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

Veterans Health Administration Performance Data

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."[26] 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.[27]

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of June 30, 2020. The figure uses blue and green data points to indicate high performance (for example, in the areas of mental health (MH) experience (exp) of care, MH population (popu) coverage, and stress discussed). Metrics that need improvement are in orange and red (for example, in the areas of hospital wide readmissions (RSRR-HWR) and health care (HC) associated (assoc) infections).

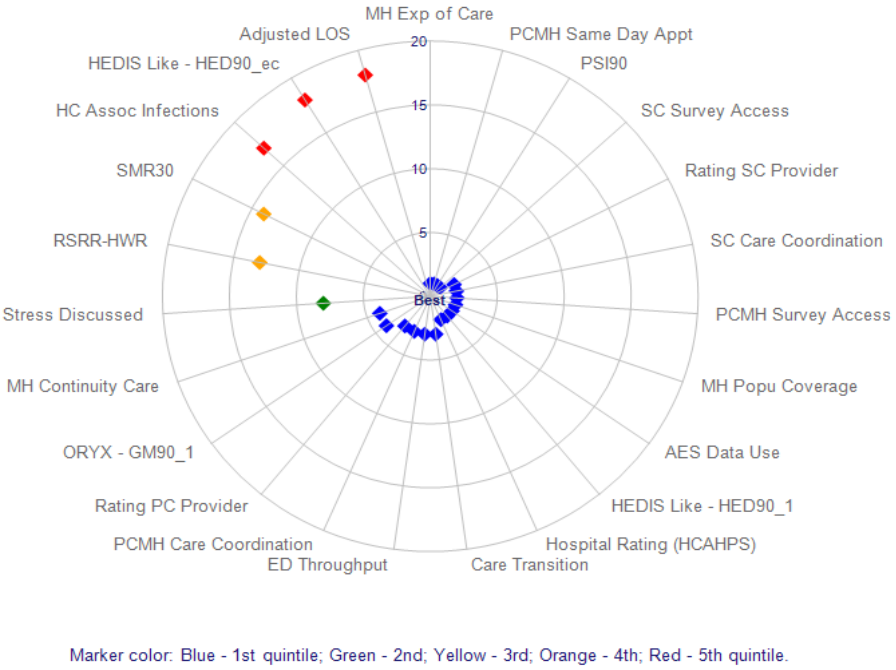


Figure 4. *Facility quality of care and efficiency metric rankings for FY 2020 quarter 3 (as of June 30, 2020).*

Source: VHA Support Service Center.

Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see appendix E.

[26] "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 VA website not publicly accessible.)

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

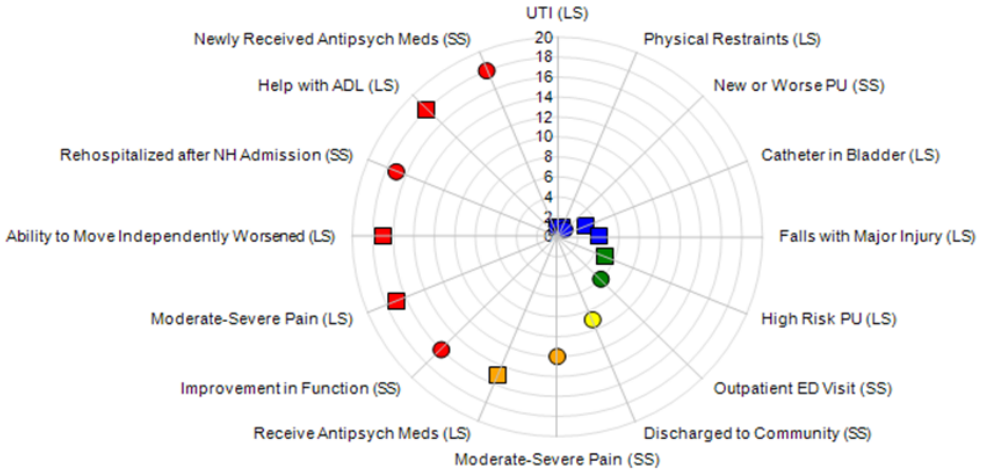
VISN 1 had 17 of 23 performance measures scoring in the first quintile as of FY 2020 quarter 3. VISN leaders reported being aware of fifth quintile items and discussed efforts to improve adjusted length of stay, healthcare effectiveness data and information set (HEDIS), and health care associated infections scores.

The SAIL Value Model also includes SAIL CLC, which is a tool to "summarize and compare performance of CLCs in the VA."[28] The SAIL model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[29]

Figure 5 illustrates the VISN's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. The figure uses blue and green data points to indicate high performance (for example, in the areas of urinary tract infections (UTI)—long-stay (LS), physical restraints (LS), new or worse pressure ulcers (PU)—short-stay (SS), and high risk PU (LS)). Measures that need improvement are in orange and red (for example, moderate-severe pain (SS), moderate-severe pain (LS), and help with activities of daily living (ADL) (LS)).

[28] 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.

[29] 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."



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

Figure 5. *CLC quality measure rankings (as of June 30, 2020).*

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

Source: VHA Support Service Center.

Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see appendix F.

The VISN made high-performing CLCs a strategic objective in FYs 2019 and 2020. VISN leaders transitioned this objective to an operational plan and continued oversight of areas such as receipt of antipsychotic medications and moderate to severe pain.

Observed Trends in Noncompliance

The OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, care coordination, and high-risk processes.

During virtual CHIP visits of VISN 1 facilities performed during the weeks of January 25 and February 1, 2021, the OIG noted trends in noncompliance for the following areas:

- QSV
  - Surgical work group
- Care coordination (inter-facility transfers)
  - Written policy
  - Monitoring and evaluation of inter-facility transfers
  - Transfer notes
  - Pertinent medical records sent to receiving facilities
  - Nurse-to-nurse communication

- High-risk processes (management of disruptive and violent behavior)
    - Committee meeting attendance
    - Staff training

In response to these trends, the Network Director stated that VISN staff would follow up with responsible facility directors, chiefs of staff, associate directors for patient care services, and associate directors.

Leadership and Organizational Risks Conclusion

The VISN's executive leaders, except for the CMO, had worked together since 2018. At the time of the virtual review, the Deputy CMO filled the CMO role in an acting capacity. The Deputy Network Director, assigned to the VISN in 2015, was the longest-serving member of the executive leadership team. The QMO and Network Director were assigned in 2017 and 2018, respectively.

Selected survey scores related to employees' satisfaction with the VISN executive leaders were higher than VHA averages. In the review of patient experience survey data, the OIG noted VISN averages for selected survey questions were higher than VHA averages.

The OIG's review of access metrics and clinical vacancies identified primary care wait times over 20 days and vacancies in certain specialties that pose a potential organizational risk. The executive team leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes. The leaders were knowledgeable within their scopes of responsibility about selected SAIL and CLC SAIL measures and should continue to take actions to sustain and improve performance. Further, the OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, care coordination, and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

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.[30] 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.[31]

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."[32] "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."[33]

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 VISN 1 and its leaders' subsequent response. 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 will report the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 1 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

[30] "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed March 23, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

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

[32] 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."

[33] 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.[34] 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.[35] Designated leaders are directly accountable for program integration and communication within their levels of responsibility. 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."[36]

To determine whether the VISN implemented and incorporated OIG-identified key processes for quality and safety, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, OIG inspectors examined the following requirements:

- Designation of a systems redesign and improvement program manager[37]
- Establishment of a systems redesign and improvement advisory group that has representation from each VISN medical center[38]
- Assignment of a chief surgical consultant who also serves as chairperson of the VISN surgical work group[39]
- Designation of a VISN lead surgical nurse who participates in the VISN surgical work group[40]
    - Chairperson of conference calls with VA facility surgical quality nurses
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[41]
    - Monitoring of facility outlier data and communication of follow-up actions to VISN and facility directors

[34] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[35] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[36] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.
[37] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.
[38] VHA Directive 1026.01.
[39] VHA Directive 1102.01(1), *National Surgery Office*, April 24, 2019, amended May 22, 2019.
[40] VHA Directive 1102.01(1).
[41] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.

  - Submission of quarterly VISN peer review data analysis reports to Quality, Safety, and Value
- Quarterly reporting of institutional disclosures to the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value[42]

Quality, Safety, and Value Findings and Recommendations

Generally, the VISN met the above requirements. The OIG made no recommendations.

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

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[43] When certain actions are taken against a provider's licenses, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the provider meets licensure requirements for VA employment.[44] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO.[45] The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with VHA policy," which includes VISN CMO oversight of facilities' processes.[46]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[47] When reports from the National Practitioner Data Bank or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined whether there was evidence of the

- Chief of Human Resources Management Service, or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements,
- Regional Counsel or designee's documented review to determine if the physician meets appointment requirements, and
- VISN CMO's concurrence and approval of the Regional Counsel or designee's review.

[43] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (The credentialing section of this handbook was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

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

[45] VHA Handbook 1100.19.

[46] VHA Handbook 1100.19.

[47] GAO, *Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6, February 2019. VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, focused on the approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards." The OIG reviewed VISN facility physicians hired after January 1, 2018, to continue efforts to identify staff not meeting VHA employment requirements since "VHA officials told us [GAO] these types of reviews are not routinely conducted…[and] that the initial review was labor intensive."

Medical Staff Credentialing Finding and Recommendation

The OIG identified weaknesses in the review and approval of one physician who had a potentially disqualifying licensure action prior to VA appointment.

VHA policy states that physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review."[48] The physicians' "credentials file[s] must be reviewed with Regional Counsel, or designee, [and]…the review and the rationale for the conclusions must be forwarded to the VISN CMO for concurrence and approval of the appointment."[49]

The OIG reviewed licensure information for 383 physicians, using publicly available data and VetPro, and did not find evidence that the CMO reviewed the credentials file and approved the VA appointment for one physician who had a potentially disqualifying licensure action.[50] The physician's license was placed on probation in 2010. Failure to conduct a documented review could lead to an inappropriate physician hire, which could subsequently affect the provision of quality care. The acting CMO stated that the hiring facility did not forward the information for CMO review, believing it was not necessary since human resources and Regional Counsel concurred with the physician's hire.

Recommendation 1

1. The Chief Medical Officer evaluates and determines any additional reasons for noncompliance and makes certain to review the credentials file and approve the VA appointment for physicians who had a potentially disqualifying licensure action.

[48] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[49] VHA Handbook 1100.19.

[50] "Physician Data Center," The Federation of State Medical Boards, accessed April 21, 2021, https://www.fsmb.org/PDC/. This is a publicly available website with a database representing state medical and osteopathic regulatory boards. It is designed to "protect the public and promote quality health care" by listing formal actions taken against physicians. VHA Handbook 1100.19. "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file."

VISN concurred.

Target date for completion: March 31, 2022

VISN response: The Chief Medical Officer reviewed and determined no additional reasons for noncompliance. The VISN hired a VISN Credentialing and Privileging Officer (CPO) in August 2021, who will train VAMC credentialing and privileging staff on the criteria for a required Chief Medical Officer (CMO) review by a presentation during the monthly meeting to be held in November 2021 with a follow up training during Quarter 2 FY 22. The CMO will educate all VAMC Chiefs of Staff on the requirement by sending a return receipt email outlining the requirement for Chief Medical Officer review prior to review by the Executive Committee of the Medical Staff for physicians who have a potentially disqualifying licensure action. A monthly audit will be performed by the CMO Office of all 8 facilities track status of notification completion. This audit will be a 100% review of all facility level appointments of physicians that have a potentially disqualifying licensure action to determine if CMO review and approval was achieved prior to the appointment. The target for audit compliance is set to 90% or greater for six consecutive months. Audit data will be reported quarterly to the VISN 1 Healthcare Delivery Council (HDC).

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that healthcare facilities provide a safe, clean, and functional environment of care for veterans, their families, visitors, and employees in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[51] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[52] VHA provides policy, mandatory procedures, and operational requirements for implementing an effective supply chain management program at VA healthcare facilities that includes responsibility for VISN-level oversight.[53]

The OIG inspection team reviewed relevant documents and interviewed VISN managers. Specifically, inspectors examined the following requirements:

- Establishment of a policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee[54]
  - Met at least quarterly
  - Documented an annual review within the previous 12 months of the VISN's
    - Emergency Operations Plan
    - Continuity of Operations Plan
    - Hazards Vulnerability Analysis
  - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval

[51] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016; VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[52] VHA Directive 1608.

[53] VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018. (The directive was rescinded and replaced by VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.)

[54] VHA Directive 0320.01.

- Assessment of inventory management programs through an annual quality control review[55]

Environment of Care Findings and Recommendations

Generally, the VISN met the above requirements. The OIG made no recommendations.

[55] VHA Directive 1761(2).

Mental Health: Suicide Prevention

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.[56] 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.[57] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[58]

VHA requires VISN leaders to appoint mental health staff to serve as a member of its primary governing body, participate on each state's suicide prevention council or workgroup, and coordinate activities with state and local mental health systems and community providers.[59]

The OIG reviewed relevant documents and interviewed managers to determine whether VISN staff complied with various suicide prevention requirements:

- Designation of a mental health professional to serve on the VISN's primary governing body and each state's suicide prevention council or workgroup
- Designation of a mental health liaison to coordinate activities with state, county, and local mental health systems and community providers

Mental Health Findings and Recommendations

The OIG observed compliance with involvement of a mental health professional in the VISN's primary governing body. However, the OIG found deficiencies with the designation of a mental health professional to serve on each state's suicide prevention council or workgroup.

VHA policy states that "VISNs must designate a mental health professional, usually one of the facilities' SPCs [suicide prevention coordinators], to serve on each State's council or workgroup on suicide prevention."[60] The OIG did not find evidence that VISN leaders designated a mental health professional to serve on each state's suicide prevention council or workgroup. Failure to have a mental health professional engaged in the state's suicide prevention activities could limit the coordination of shared resources between VISN facilities and state agencies. The Mental Health Director acknowledged not designating an individual to serve on the state's council or

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

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

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

[59] Principal Deputy Under Secretary for Health Operations and Management (10N) Memorandum, *Patients at High-Risk for Suicide*, April 24, 2008. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[60] VHA Handbook 1160.01.

workgroup and reported believing that facility leaders are better suited to designate staff for this role because they are more aware of their facility's resources.

Recommendation 2

2. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain to designate a mental health professional to serve on each state's suicide prevention council or workgroup.

VISN concurred.

Target date for completion: December 31, 2021

VISN response: The Network Director evaluated and found no additional reasons for noncompliance. To demonstrate evidence of Network Director designation, designation memorandums appointing metal health professionals to each New England State's suicide prevention council or workgroup will be sent to the selected professionals currently filling those roles no later than December 31, 2021. Copies of signed memorandums will provide evidence of Network Director designation and acceptance of the appointments documented in minutes of the VISN Mental Health Executive Committee.

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 patients when their needs can be better managed at another facility.[61]

When VA or non-VA staff transfer a patient "to a VA facility in a manner that violates [VA] policy," the VISN CMO is responsible for contacting the transferring facility and conducting a fact-finding review to determine if the transfer was appropriate.[62] Examples of patient transfers that do not comply with VA policy include

- patients who were not appropriately screened and/or did not consent prior to transfer,
- patients who were not transferred with qualified personnel or equipment,
- transfers that were not approved by a VA physician, or
- pertinent medical records that were not sent with patients at the time of transfer.[63]

The OIG reviewed relevant documents and interviewed key managers to determine whether the VISN CMO contacted the transferring facility and conducted a fact-finding review for reported cases of possible inappropriate transfers to a VA facility in calendar year 2020.

Care Coordination Findings and Recommendations

The CMO stated that no incidents of inappropriate inter-facility transfers were reported during calendar year 2020. The OIG made no recommendations.

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

Women's Health: Comprehensive Care

Women were estimated to represent approximately 10 percent of the veteran population as of September 30, 2019.[64] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans is anticipated to increase.[65] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[66]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in all VA medical facilities.[67] VHA also requires that VISN leaders appoint a lead women veterans program manager (WVPM) to serve as the VISN representative on women veterans' issues and identify gaps through "VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN."[68]

To determine whether the VISN complied with OIG-selected VHA requirements, the inspection team reviewed relevant documents and interviewed selected managers on the following VISN-level requirements:

- Appointment of a lead WVPM
- Establishment of a multidisciplinary team that executes strategic planning activities for comprehensive women's health care
- Provision of quarterly program updates to executive leaders
- Monthly calls held with facility WVPMs and women's health medical directors
- Completion of annual site visits at each VISN facility
    - Needs assessment conducted
    - Progress toward implementation of recommended interventions tracked

[64] "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.

[65] "Veteran Population," National Center for Veterans Analysis and Statistics, accessed September 16, 2019. https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf.

[66] Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, Final Report, April 2015.

[67] VHA Directive 1330.01(4), *Health Care Services for Women Veterans,* February 15, 2017, amended January 8, 2021.

[68] VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018.

- Assessments to identify staff education gaps
  - Development of educational program and/or resources when needs identified
- Availability of VISN-level support staff for analyzing data and implementing performance improvement projects
- Analysis of women veterans access and satisfaction data
  - Implementation of improvement actions when recommended

Women's Health Findings and Recommendations

The OIG found general compliance with the appointment of a lead WVPM, completion of annual site visits, and analysis of access and satisfaction data. However, the OIG found deficiencies with quarterly program updates to VISN leaders, staff education gap analyses, and VISN-level support staff availability.

VHA requires that the lead WVPM provides quarterly program updates to the Network Director or the CMO.[69] The OIG did not find evidence that the lead WVPM provided quarterly program updates to the required VISN leaders. Failure to provide routine updates could prevent leaders from properly allocating resources to support comprehensive women veterans health care. The lead WVPM reported meeting with the CMO around the beginning of the year, holding a mid-year data review, and meeting at additional times as needed. The lead WVPM could not identify a reason for noncompliance.

Recommendation 3

3. The Network Director determines the reasons for noncompliance and ensures that the lead Women Veterans Program Manager provides quarterly program updates to required Veterans Integrated Service Network leaders.

VISN concurred.

Target date for completion: March 31, 2022

VISN response: The Network Director reviewed and determined a need for structured scheduled reporting from the WVPM to the CMO. The VISN lead WVPM will be scheduled for a quarterly meeting with the CMO to provide a program update. The lead WVPM will prepare a PowerPoint or other deliverable in advance of the meeting and capture minutes to summarize the focus of discussion. The target is to complete two consecutive quarters in compliance, as evidenced by minutes for the completed meetings.

[69] VHA Directive 1330.01(4).

VHA also requires that the lead WVPM conducts "assessments to identify VA staff education gaps related to women's health" and develop or adapt "educational programs, materials, and resources where gaps are identified."[70] The lead WVPM reported not conducting educational gap assessments. Failure to address educational gaps could limit staff's ability to provide key women veterans services. The lead WVPM stated that facility staff self-identify their needs and implement educational programs at the local level, and that this has been the practice for several years.

Recommendation 4

4. The Network Director evaluates and determines any additional reasons for noncompliance and ensures the lead Women Veterans Program Manager conducts assessments to identify staff's women's health education gaps and develops or adapts educational programs, materials, or resources where gaps are identified.

VISN concurred.

Target date for completion: March 31, 2022

VISN response: The Network Director reviewed and determined that the COVID pandemic impacted the lead WVPM's follow-through on this annual process. Moving forward, the VISN lead WVPM will complete an educational gap assessment that involves personnel at all 8 facilities. The results of the assessment will be reported to the CMO during a quarterly review, including an action plan for educational program development or adaptation. Completion of educational program action plan will also be reported during the CMO review, with appropriate deliverables demonstrating completion. Documentation of the above activities will be captured in minutes from the CMO WVPM program update meetings.

VHA requires the lead WVPM to have "VISN-level staff support for data analysis, project implementation, performance improvement projects as well as resources to ensure equitable and high-quality care of women Veterans."[71] The lead WVPM reported being able to get assistance with small tasks but not with data analysis or projects. The lack of VISN-level staff to support women's health program data analysis and projects could impede timely execution of project implementation. The lead WVPM reported believing that the lack of designated support staff was a matter of resource allocation by the VISN.

[70] VHA Directive 1330.02.

[71] VHA Directive 1330.02.

Recommendation 5

5. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that the lead Women Veterans Program Manager has Veterans Integrated Service Network-level support staff for data analysis and performance improvement projects.

VISN concurred.

Target date for completion: March 31, 2022

VISN response: The Network Director reviewed and determined a failure by the VISN lead WVPM to request available VISN administrative, data analysis or improvement resources when needed to support the Women's Health program. A VISN Chief Medical Office Health Systems Specialist has been assigned to assist the lead WVPM with multiple tasks since March 2021. Moving forward, the VISN lead WVPM will include requests for VISN data analysis, administrative or improvement support as a standing agenda item in the quarterly CMO program update meetings. Minutes from those meetings will reflect new requests as well as documentation of completed support activities. The target for completion is to share minutes from two consecutive quarterly meetings that demonstrate compliance with this requirement.

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 within this VISN, the OIG conducted a detailed review of key clinical and administrative processes associated with promoting quality care and provided five recommendations on issues that may adversely affect patients. While the OIG's recommendations are not a comprehensive assessment of the caliber of services delivered within this VISN, they illuminate areas of concern and guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines five OIG recommendations that are attributable to the Network Director and Chief Medical Officer. The intent is for VISN leaders to use these recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinical vacancies • Oversight inspections • VHA performance data • Observed trends in noncompliance	Five OIG recommendations that can lead to patient and staff safety issues or adverse events are attributable to the Network Director and Chief Medical Officer. See details below.
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations	The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 1 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Systems Redesign and Improvement Program staff and requirements • VISN Surgical Work Group • Collection, analysis, and action in response to VISN peer review data • Quarterly reporting of institutional disclosures for each facility	• None	• None
Medical Staff Credentialing	• Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements • Regional Counsel or designee's documented review to determine the if the physician meets appointment requirements and subsequent concurrence/approval by VISN CMO	• The Chief Medical Officer reviews the credentials file and approves the VA appointment for physicians who had a potentially disqualifying licensure action.	• None
Environment of Care	• Establishment of a policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN Emergency Management Committee • Assessment of inventory management programs through an annual quality control review	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Suicide Prevention	• Designation of a mental health professional to serve on the VISN's primary governing body and each state's suicide prevention council or workgroup • Designation of a mental health liaison to coordinate activities with state, county, and local mental health systems and community providers	• None	• The Network Director designates a mental health professional to serve on each state's suicide prevention council or workgroup.
Care Coordination	• CMO contact and fact-finding review for reported cases of possible inappropriate inter-facility patient transfers	• None	• None
Women's Health: Comprehensive Services	• Lead women veterans program manager appointed • Multidisciplinary team that executes strategic planning activities established • Quarterly program updates provided to required executive leaders • Monthly calls held with facility women veterans program managers and women's health medical directors • Annual site visits completed at each VISN facility • Staff education gap assessments conducted • Support staff available • Women veterans access and satisfaction data analyzed	• None	• The lead Women Veterans Program Manager provides quarterly program updates to required VISN leaders. • The lead Women Veterans Program Manager conducts assessments to identify staff's women's health education gaps and develops or adapts educational programs, materials, or resources where gaps are identified. • VISN-level support staff are available for data analysis and performance improvement projects.

Appendix B: VISN 1 Profile

The table below provides general background information for VISN 1.

Table B.1. Profile for VISN 1
(October 1, 2017, through September 30, 2020)

Profile Element	VISN Data FY 2018*	VISN Data FY 2019†	VISN Data FY 2020‡
Total medical care budget	$3,026,590,354	$3,208,805,948	$3,673,147,632
Number of:			
• Unique patients	261,869	262,016	252,351
• Outpatient visits	3,594,341	3,671,643	3,304,971
• Unique employees§	12,332	12,667	12,625
Type and number of operating beds:			
• Community living center	700	611	611
• Domiciliary	200	200	200
• Hospital	790	790	775
• Residential rehabilitation	91	91	91
Average daily census:			
• Community living center	399	446	395
• Domiciliary	153	137	92
• Hospital	500	510	451
• Residential rehabilitation	64	70	50

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

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

**October 1, 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: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 1 (October 1, 2019, through September 30, 2020)

Questions	Scoring	Facility	Average Score*
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	VHA	69.5
		VISN 1	75.2
		Bedford, MA	–
		Boston, MA	77.0
		Leeds, MA	–
		Manchester, NH	–
		Providence, RI	71.3
		Augusta, ME	77.4
		West Haven, CT	71.3
		White River Junction, VT	83.2
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 "Agree" and "Strongly Agree" responses.	VHA	82.5
		VISN 1	88.7
		Bedford, MA	88.7
		Boston, MA	89.5
		Leeds, MA	86.3
		Manchester, NH	89.0
		Providence, RI	88.6
		Augusta, ME	87.9
		West Haven, CT	89.7
		White River Junction, VT	89.1

Questions	Scoring	Facility	Average Score*
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 "Agree" and "Strongly Agree" responses.	VHA	84.8
		VISN 1	89.9
		Bedford, MA	88.4
		Boston, MA	93.0
		Leeds, MA	88.6
		Manchester, NH	90.2
		Providence, RI	88.3
		Augusta, ME	89.4
		West Haven, CT	88.1
		White River Junction, VT	92.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 21, 2020).

**Inpatient data were not available for the Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA), Manchester VAMC (NH), or VA Central Western Massachusetts HCS (Leeds).*

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Clinical Assessment Program Review of the White River Junction VA Medical Center, Vermont, Report No. 16-00556-244, June 20, 2017	December 2016	0	24	–	0
Comprehensive Healthcare Inspection Program Review of the Providence VA Medical Center, Providence, Rhode Island, Report No. 17-01761-129, March 21, 2018	August 2017	0	12	–	0
Comprehensive Healthcare Inspection Program Review of the VA Boston Healthcare System, Massachusetts, Report No. 17-05570-06, October 23, 2018	April 2018	0	7	–	0
Comprehensive Healthcare Inspection Program Review of the VA Maine Healthcare System, Augusta, Maine, Report No.18-01152-14, November 28, 2018	June 2018	0	7	–	0
Review of Delays in Clinical Consult Processing at VA Boston Healthcare System, Massachusetts, Report No. 17-05504-107, April 11, 2019	June 2018	0	0	–	–

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Deficiencies in Sterile Processing Services and Decreased Surgical Volume at the VA Connecticut Healthcare System, Newington, Connecticut and West Haven, Connecticut, Report No. 19-00075-14, November 20, 2019	December 2018 February 2019	2	9	1*	2†
Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, Connecticut, Report No. 18-04675-23, November 20, 2019	March 2019	0	13	–	7‡
Comprehensive Healthcare Inspection of the Manchester VA Medical Center, New Hampshire, Report No. 19-00040-10, November 25, 2019	June 2019	0	17	–	5§
Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts, Report No. 19-00038-63, January 13, 2020	June 2019	0	30	–	5‖
Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts, Report No. 19-00043-66, January 13, 2020	June 2019	0	21	–	15#
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 1: VA New England Healthcare System, Bedford, Massachusetts, Report No. 19-06866-68, January 29, 2020	June 2019	12	0	2**	–

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds, Report No. 19-09669-236, August 20, 2020	November 2019	0	7	–	5††

Source: Inspection/survey results verified with the Quality Management Health System Specialist on February 3, 2021.

**As of October 2021, no recommendations remained open.*

†*As of October 2021, 1 recommendation remained open.*

‡*As of October 2021, no recommendations remained open.*

§*As of October 2021, 2 recommendations remained open.*

‖*As of October 2021, 1 recommendation remained open.*

#*As of October 2021, 3 recommendations remained open.*

***As of October 2021, no recommendations remained open.*

††*As of October 2021, no recommendations remained open.*

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
ED Throughput	Composite measure for timeliness of care in the emergency department (ED)t	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)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
MH Continuity Care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value
PCMH Care Coordination	Patient-centered medical home (PCMH) care coordination	A higher value is better than a lower value

Measure	Definition	Desired Direction
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 primary care (PC) providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care (SC) providers	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: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) 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.
Receive Antipsych Meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.

Measure	Definition
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 30, 2021

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

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

To: Director, Office of Healthcare Inspections (54CH04)

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 1: VA New England Healthcare System.

2. I concur with the findings and recommendations as well as the submitted action plans.

(Original signed by:)

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

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