VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Hudson Valley Health Care System in Montrose, New York

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Figure 1. *VA Hudson Valley Health Care System in Montrose, New York.*
Source: https://vaww.va.gov/directory/guide/ (accessed June 2, 2021).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Hudson Valley Health Care System, which includes two medical center campuses—the Franklin Delano Roosevelt Hospital (Montrose) and the Castle Point VA Medical Center (Wappingers Falls)—and multiple outpatient clinics in New York. Both campuses provide outpatient and urgent care services and have at least one community living center. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. COVID-19 pandemic readiness and response[1]

2. Quality, safety, and value

3. Registered nurse credentialing

4. Medication management (targeting remdesivir use)[2]

5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)

6. Care coordination (spotlighting inter-facility transfers)

7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual review of the VA Hudson Valley Health Care System during the week of June 7, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities

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

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

limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual review, the healthcare system's leadership team consisted of the System Director, Chief of Staff, Associate Director for Patient Care Services, Associate Director, and Assistant Director. Organizational communications and accountability were managed through a committee reporting structure, with Executive Governance Board oversight of several working groups. The Director served as the chairperson of the Executive Governance Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. Leaders monitored patient safety and care through the Quality Safety Value Committee, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the healthcare system's leaders had worked together for approximately one year. The Director, assigned in May 2020, was the newest member of the executive team, but had worked in different capacities in this healthcare system for 24 years. The Associate Director for Patient Care Services, who had been in the role since 2015, was the most tenured leader, and the Chief of Staff was appointed in 2019. The Associate Director served as the Assistant Director for over one year prior to being promoted. The Associate Director had also been covering the responsibilities of the vacant assistant director position since December 2020.

The healthcare system's fiscal year 2020 annual medical care budget of $265,008,851 increased by over 14 percent compared to the previous year, and the executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

The OIG found the healthcare system averages for the selected All Employee Survey leadership questions were similar to or lower than the VHA averages.[3] Scores for the Director and Assistant Director were consistently higher than those for VHA and the healthcare system. Scores related to the Associate Director were generally similar to or higher than the VHA and healthcare system averages except for the moral distress question.[4] The All Employee Survey, which was initiated in September 2020, was not reflective of employee satisfaction with the Associate Director who was in place at the time of the OIG virtual visit. The Associate Director, who was promoted to the role in December 2020, served as the Assistant Director during the 2020 All Employee Survey. The Associate Director for Patient Care Services appeared to have an opportunity to address employee feelings regarding leaders' honesty and integrity and their level of respect.

For this system, overall patient satisfaction survey results generally reflected higher ratings than the VHA averages for outpatient patient-centered medical home and specialty care. However, inpatients were less likely to recommend the hospital than VHA inpatients nationally. Additionally, survey results indicated opportunities to improve female outpatients' perceptions of their patient-centered medical home and specialty care providers and their ability to obtain routine specialty care appointments.

The OIG's review of the system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG noted leadership turnover in the Quality Management Service as an area of vulnerability.

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

The executive leaders were very knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures.

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[3] 2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.)

[4] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework." The 2020 All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

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

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

Leaders also understood Community Living Center SAIL measures.[7] In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The healthcare system complied with most of the requirements for quality, safety, and value. However, the OIG identified a weakness with protected peer reviews.[8]

Registered Nurse Credentialing

The OIG found that registered nurses hired by the healthcare system between July 1, 2020, and May 9, 2021, were free from potentially disqualifying licensure actions. However, the OIG found a deficiency with the completion of primary source verification prior to appointment.

Care Coordination

The OIG observed general compliance with requirements for the use of the VA *Inter-Facility Transfer Form* or a facility-defined equivalent by the appropriate providers and monitoring and evaluation of inter-facility transfers.[9] However, the OIG identified deficiencies with the establishment of a facility policy for inter-facility transfers, completion of required transfer form elements, transmission of patients' active medication lists and advance directives to receiving facilities, and nurse-to-nurse communication between facilities.

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

[8] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements.

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

High-Risk Processes

The OIG found the healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with staff training.

Conclusion

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

VA Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 62–63). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

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

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

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

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

1. Leadership and organizational risks

2. COVID-19 pandemic readiness and response[5]

3. Quality, safety, and value (QSV)

4. Registered nurse (RN) credentialing

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

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

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

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

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

5. Medication management (targeting remdesivir use)[6]

6. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)

7. Care coordination (spotlighting inter-facility transfers)

8. High-risk processes (examining the management of disruptive and violent behavior)

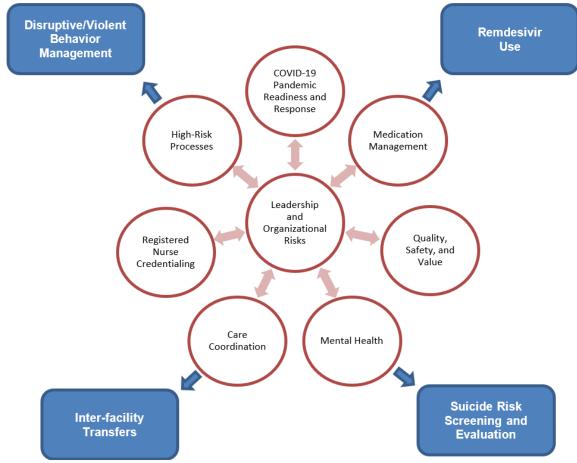***Figure 2***. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

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

Methodology

The VA Hudson Valley Health Care System includes the Franklin Delano Roosevelt Hospital (Montrose), Castle Point VA Medical Center (Wappingers Falls), and multiple outpatient clinics in New York. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from October 23, 2017, through June 10, 2021, the last day of the unannounced multiday evaluation.[8] During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

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

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

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

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership position stability and engagement

2. Budget and operations

3. Staffing

4. Employee satisfaction

5. Patient experience

6. Accreditation surveys and oversight inspections

7. Identified factors related to possible lapses in care and the healthcare system response

8. VHA performance data (healthcare system)

9. VHA performance data (community living center (CLC))[11]

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the System Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director.[12] The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

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

[12] The assistant director position had been vacant since December 2020 and the duties were being covered by the Associate Director.
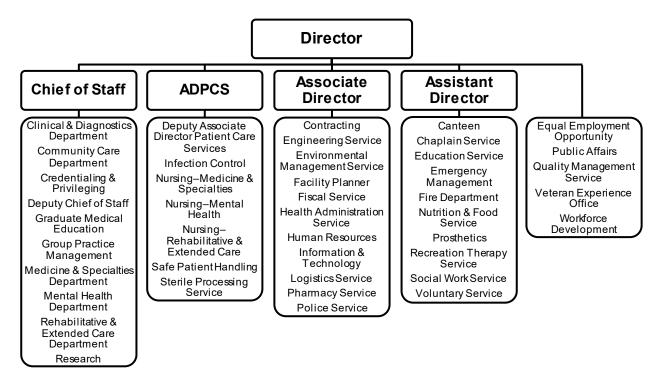
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                              ┌─────────────┐
                              │  Director   │
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Chief of Staff	**ADPCS**	**Associate Director**	**Assistant Director**	
Clinical & Diagnostics Department	Deputy Associate Director Patient Care Services	Contracting	Canteen	Equal Employment Opportunity
Community Care Department	Infection Control	Engineering Service	Chaplain Service	Public Affairs
Credentialing & Privileging	Nursing–Medicine & Specialties	Environmental Management Service	Education Service	Quality Management Service
Deputy Chief of Staff	Nursing–Mental Health	Facility Planner	Emergency Management	Veteran Experience Office
Graduate Medical Education	Nursing–Rehabilitative & Extended Care	Fiscal Service	Fire Department	Workforce Development
Group Practice Management	Safe Patient Handling	Health Administration Service	Nutrition & Food Service	
Medicine & Specialties Department	Sterile Processing Service	Human Resources	Prosthetics	
Mental Health Department		Information & Technology	Recreation Therapy Service	
Rehabilitative & Extended Care Department		Logistics Service	Social Work Service	
Research		Pharmacy Service	Voluntary Service	
		Police Service		

Figure 3. *Healthcare system organizational chart.*

Source: VA Hudson Valley Health Care System (received June 7, 2021).

At the time of the OIG inspection, the executive team had worked together for approximately one year, with the Director in place since May 2020 and the Chief of Staff and ADPCS serving in their roles since 2019 and 2015, respectively (see table 1). The Associate Director served as the Assistant Director for over one year prior to being promoted. Since December 2020, the Associate Director had continued to cover the responsibilities of the vacant assistant director position.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
System Director	May 24, 2020
Chief of Staff	August 18, 2019
Associate Director for Patient Care Services	December 27, 2015
Associate Director	December 6, 2020
Assistant Director	Vacant

Source: VA Hudson Valley Health Care System acting Chief, Human Resources Officer for VISN 2 and acting Assistant Chief, Human Resources Officer (received June 8, 2021).

The Director served as the chairperson of the Executive Governance Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform

organizational management and strategic planning. The Executive Governance Board oversaw the Administrative Executive, Healthcare Delivery, and Organizational Health councils; and the Quality Safety Value Committee. These leaders monitored patient safety and care through the Quality Safety Value Committee, which was responsible for tracking and trending quality of care and patient outcomes and also reported to the Executive Governance Board (see figure 4).
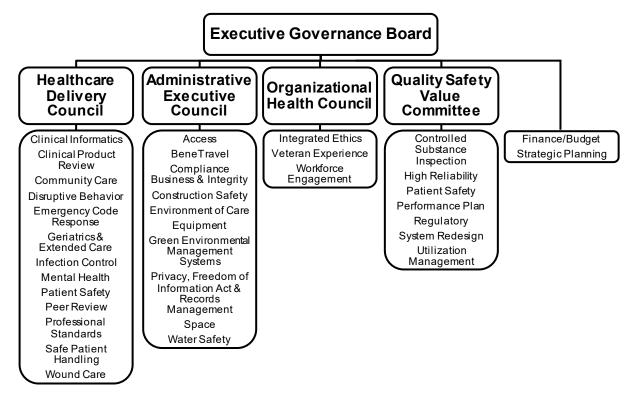
Executive Governance Board

Healthcare Delivery Council
- Clinical Informatics
- Clinical Product Review
- Community Care
- Disruptive Behavior
- Emergency Code Response
- Geriatrics & Extended Care
- Infection Control
- Mental Health
- Patient Safety
- Peer Review
- Professional Standards
- Safe Patient Handling
- Wound Care

Administrative Executive Council
- Access
- BeneTravel
- Compliance Business & Integrity
- Construction Safety
- Environment of Care
- Equipment
- Green Environmental Management Systems
- Privacy, Freedom of Information Act & Records Management
- Space
- Water Safety

Organizational Health Council
- Integrated Ethics
- Veteran Experience
- Workforce Engagement

Quality Safety Value Committee
- Controlled Substance Inspection
- High Reliability
- Patient Safety
- Performance Plan
- Regulatory
- System Redesign
- Utilization Management

- Finance/Budget
- Strategic Planning

Figure 4. Healthcare system committee reporting structure.
Source: VA Hudson Valley Health Care System (received June 7, 2021).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Deputy ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.[13] In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

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[13] The ADPCS was on leave during the week of the virtual CHIP visit. The OIG team conducted the nursing leadership interview with the Deputy ADPCS.

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $265,008,851 increased by over 14 percent compared to the previous year's budget of $232,224,240.[14] When asked about the effect of the change on the healthcare system's operations, the Director explained that Level 3 facilities, like the VA Hudson Valley Health Care System, have a lower complexity workload when compared to Level 1 and 2 facilities. The Director indicated that because the budget is based on workload, the system starts with a budget deficit.[15] The Director reported that due to the system's size (300 acres and 2.5 million square feet of buildings) and aging infrastructure (some buildings were 75 to 100 years old), maintenance costs were high. Specifically, the Director stated that the old air conditioning systems and plumbing required significant resources for maintenance.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[16] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[17] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[18]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[19] The executive leaders confirmed that the occupations listed in table 2 generally remained the top clinical and nonclinical shortages at the time of the OIG inspection. To address the shortages, the executive leaders reported looking at special salary rates and offering recruitment and retention incentives.

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[14] VHA Support Service Center.

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

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

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

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

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

The Associate Director discussed reaching out to technical schools in the area for air conditioning mechanics. The Chief of Staff and Deputy ADPCS reported reviewing processes to determine which positions were needed to ensure they were using staffing resources appropriately. Additionally, the leaders described retaining contract staff, realigning current staff, and using VISN resources as interim strategies to alleviate service and section stresses caused by the current occupational staffing shortages.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Nursing Assistant	1. Budget Analysis
2. Medical Technologist	2. Air Conditioning Equipment Mechanic
3. Nurse	3. General Facilities and Equipment (Biomed Equipment Support Specialist)
4. Diagnostic Radiologic Technologist	4. Accounting Technician
5. Pharmacist	5. Medical Support Assistance

Source: VA OIG.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[20] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[21] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey, which was initiated in September 2020 and covered employee experiences from October 1, 2019, through September 30, 2020.[22] The survey results for the Associate Director were not reflective of employee satisfaction with the Associate Director who was in place at the time of the OIG virtual visit. The current Associate Director, who assumed the role in December 2020, served as the Assistant Director during the 2020 All Employee Survey review period.

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[20] "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.)

[21] "AES Survey History."

[22] Ratings are based on responses by employees who report to the Director, ADPCS, Associate Director, and Assistant Director. The Chief of Staff ratings are based on responses from all employees aligned under the Chief of Staff.

Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. The OIG found the healthcare system averages for the selected survey leadership questions were similar to or lower than the VHA averages.[23] Scores for the Director and Assistant Director were consistently higher, and scores for the Associate Director were generally similar to or higher, than those for VHA and the healthcare system. The ADPCS scores were similar to or higher than those for VHA and the system but highlighted opportunities to improve employees' perceptions that leaders maintain honesty and integrity and their respect for senior leaders.

The Director, who had worked in different capacities at the healthcare system for 24 years, reported the uniqueness of advancing from entry level to Director within the same system. The Director stated that this experience was an asset to the system and made staff more comfortable bringing forward ideas or concerns.

The Director explained that communication, workload, accountability, and growth were leadership priorities. The Associate Director spoke of the importance of information being communicated beyond the chief level and reaching frontline staff. Additionally, the Associate Director stated the need to explain leaders' decisions and provide staff with information to help them understand why decisions were made. The Director reported that 80 supervisors had completed servant leader training.

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

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	70.4	91.3	65.3	87.0	71.8	90.6
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.4	4.3	3.3	3.6	3.8	4.6
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	4.7	3.5	3.4	3.8	4.8
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.6	4.4	3.6	3.4	3.6	4.7

Source: VA All Employee Survey (accessed May 10 and 11, 2021).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[24] The healthcare system averages for the selected survey questions were

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[24] Ratings are based on responses by employees who report to the Director, ADPCS, Associate Director, and Assistant Director. The Chief of Staff ratings are based on responses from all employees aligned under the Chief of Staff.

similar to or less favorable than the VHA averages. Scores related to the Director, ADPCS, and Assistant Director were consistently better than those for VHA and the healthcare system. The Associate Director averages were similar to the VHA and healthcare system averages, except for the moral distress question, which was less favorable. The Director reported that acting staff had rotated into the associate director position until it was permanently filled in December 2020 and believed that this affected the survey averages.

The executive leadership team reported attending staff meetings, conducting rounds, and following up regarding staff concerns to improve trust and safety in the system. The executive leaders were hopeful that ongoing communication and role modeling will lead to an improvement in attitudes toward the workplace.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.6	4.7	3.5	4.2	3.8	4.8
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.6	4.5	3.5	–*	3.6	4.3
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)– 6 (Every Day)	1.4	1.5	0.3	1.6	1.0	2.0	0.8

Source: VA All Employee Survey (accessed May 10 and 11, 2021).

*Data were not available for this survey question for the ADPCS.

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[25] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop

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

Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[26]

The Director reported implementing strategies that included placement of the official poster in a high-traffic area to allow staff to sign the poster and learn about the initiative. The leaders spoke of ongoing efforts to create a harassment-free healthcare environment. For example, the Director reported the creation of a platform to allow staff to anonymously communicate concerns to leaders. Additionally, the Chief of Staff and the Deputy ADPCS shared ideas about how communication and education supported a harassment-free environment.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The healthcare system averages for the selected survey questions were slightly lower than the VHA averages. Scores for the Director, ADPCS, and Assistant Director were consistently higher than the VHA averages. These leaders appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.

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

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	3.7	4.5	3.7	4.8	3.6	4.8
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)– 5 (Strongly Agree)	4.1	3.9	4.8	3.9	5.0	4.0	4.8
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.7	4.6	3.6	5.0	3.6	4.6

Source: VA All Employee Survey (accessed May 10 and 11, 2021).

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the healthcare system.[27] For this system, the overall patient satisfaction survey results generally reflected higher care ratings than the VHA averages in outpatient patient-centered medical home and specialty care. However,

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

inpatients appeared less inclined than VHA respondents nationally to recommend the hospital to family and friends.

The Chief of Staff and Deputy ADPCS reported working with the Nutrition and Food Service to improve the quality of food and enable patients to place on-demand orders when in the hospital. The Chief of Staff and Deputy ADPCS also stated that staff created admission and discharge packets for veterans to support follow-up care. Packets included a discharge checklist that was used to ensure all appointments were set up and communicated to the veteran. Additionally, the leaders explained that veterans received a 30-day follow-up call to ensure continuity of care.

Leaders reported that staff were invested in improving the patient experience. They shared one example of a nursing assistant who suggested the mattresses in the hospital may not be comfortable for the veterans. After some research, including evaluation by the wound care nurse, leaders purchased new mattresses for the inpatient unit.

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

Questions	Scoring	VHA Average	VA Hudson Valley Health Care System Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	61.3
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	87.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	90.9

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

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

by 2048.[28] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). The results for male respondents were generally more favorable than the corresponding VHA averages, except for the results related to recommending the hospital to family and friends. For female respondents, the survey results indicated opportunities to improve perceptions of providers within outpatient patient-centered medical home and specialty care settings and to increase the ability to obtain routine appointments with specialty care providers when needed.

System leaders appeared actively engaged with male and female patients. The leaders spoke of working to increase the number of female providers and offering services specific to women veterans.

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

**Table 7. Inpatient Survey Results on Experiences by Gender
(October 1, 2019, through September 30, 2020)**

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average‡
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	60.3	–
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	90.0	–
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	88.9	–

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

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

†The healthcare system averages are based on 106–107 male respondents, depending on the question.

‡Due to low number of respondents, there were no data available.

Table 8. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	**Female Average**	**Male Average**	**Female Average**
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	57.9	60.7
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	63.9	57.8
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	78.6	61.8

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

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

† The healthcare system averages are based on 502–1,586 male and 21–53 female respondents, depending on the question.

Table 9. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Healthcare System †	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	62.9	58.2
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	74.0	48.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	85.4	64.7

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

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

†The healthcare system averages are based on 358–1,008 male and 11–28 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[29]
Table 10 summarizes the relevant system inspections most recently performed by the OIG and

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

The Joint Commission (TJC).[30] At the time of the OIG review, the system had closed all recommendations for improvement issued since the previous CHIP site visit conducted in October 2017.[31]

The OIG team also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities.[32] Although the healthcare system's lab accreditation with the College of American Pathologists ended in 2020, the Department of VA Pathology and Laboratory Medicine Service, National Enforcement Office conducted a review and accredited the laboratory.[33] Additional results included the Long Term Care Institute's inspection of the system's CLCs.[34]

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

[31] VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA Hudson Valley Health Care System, Montrose, New York*, Report No. 17-05399-194, June 26, 2018.

[32] VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment "is supported through a system-wide, long-term joint collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs."

[33] "About the College of American Pathologists," College of American Pathologists, accessed February 20, 2019, https://www.cap.org/about-the-cap. According to the College of American Pathologists, for 75 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." Additionally, as stated in VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists. The system was transitioning from College of American Pathologists to Joint Commission accreditation for laboratory services.

[34] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the VA Hudson Valley Health Care System, Montrose, New York*, Report No. 17-05399-194, June 26, 2018)	October 2017	6	0
TJC Hospital Accreditation	April 2018	25	0
TJC Behavioral Health Care Accreditation		5	0
TJC Home Care Accreditation		4	0

Source: OIG and TJC (inspection/survey results received from the Quality Management Specialist on June 7, 2021).

Identified Factors Related to Possible Lapses in Care and Healthcare System Responses

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

Table 11 lists the reported patient safety events from October 23, 2017 (the prior OIG CHIP site visit), to June 7, 2021.[35]

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

**Table 11. Summary of Selected
Organizational Risk Factors
(October 23, 2017, through June 7, 2021)**

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

Source: VA Hudson Valley Health Care System's Patient Safety Manager (received June 7, 2021).

The Director reported being informed of serious adverse patient events through morning huddles and frequently being notified by individuals involved with the events. The Director and interim Chief, Quality Management were able to speak knowledgeably about the progress or status of actions to improve the quality and safety of care, including the implementation of action plans, monitoring of outcomes, and closure of actions. Discussion with the Director revealed a collaborative decision-making process with the Chief of Staff, and quality management and VISN staff to determine when an institutional disclosure was warranted.

The OIG identified staff turnover in the Quality Management Service as an area of vulnerability. At the time of the inspection, the Quality Management Service was experiencing turnover in the chief, systems redesign and improvement coordinator, and risk manager positions, with multiple staff serving to cover these roles. In response to the turnover that occurred with the risk manager position, system leaders created a hybrid position for a staff member trained to work in both risk management and patient safety. The Quality Management Service leaders contracted with the previous Risk Manager, who then trained the incoming team member.

Veterans Health Administration Performance Data for the Healthcare System

The VA Office of Operational Analytics and Reporting developed 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."[36] 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.[37]

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

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

The executive leaders were very knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures and CLC SAIL models.

Figure 5 illustrates the healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the VA Hudson Valley Health Care System performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of rating [of] specialty care (SC) provider, SC care coordination, and adjusted length of stay (LOS)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, health care (HC) associated (assoc) infections, stress discussed, and mental health (MH) continuity [of] care).[38]

Figure 5. System quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 2020).
Source: VHA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.

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

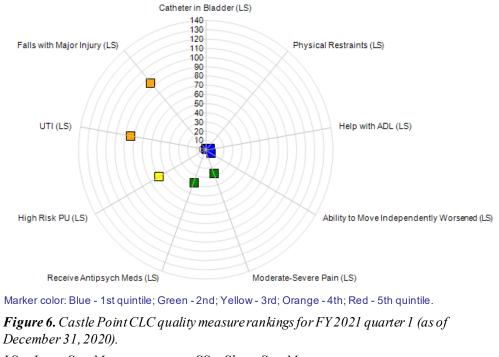## Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[39] The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[40]

Figures 6 and 7 illustrate the system's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. Figure 6 displays the Castle Point VA Medical Center's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of catheter in bladder–long-stay (LS), physical restraints (LS), and moderate-severe pain (LS)). Metrics in the fourth quintile need improvement and are denoted in orange (for example, urinary tract infections (UTI) (LS), and falls with major injury (LS)).[41]

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[39] 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.

[40] 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."

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

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

Figure 6. *Castle Point CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 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.

Figure 7 displays the Franklin Delano Roosevelt Hospital's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of physical restraints (LS), new or worse pressure ulcer (PU)–short-stay (SS), and catheter in bladder (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, high risk PU (LS), rehospitalized after nursing home (NH) admission (SS), and falls with major injury (LS)).[42]

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

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

Figure 7. Franklin Delano Roosevelt CLC Quality Measure Rankings for FY 2021 quarter 1 (as of December 31, 2020).

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG inspection, the executive team had worked together for approximately one year. The Director, assigned in May 2020, had worked in different capacities in this healthcare system for 24 years and, at the time of the inspection, served as the chairperson of the Executive Governance Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The healthcare system's FY 2020 annual medical care budget of $265,008,851 increased by over 14 percent compared to the previous year, and the executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

The OIG found the healthcare system averages for the selected survey leadership questions were similar to or lower than the VHA averages. Notably, the Director and Assistant Director's scores were consistently higher than those for VHA and the system, but the ADPCS's scores highlighted opportunities to improve employees' feelings regarding leaders' honesty and integrity and their level of respect.

For this system, the OIG noted overall patient satisfaction with outpatient care. However, system leaders have opportunities to improve female patients' perceptions of outpatient providers and the scheduling of their routine appointments with specialty providers when needed.

The OIG's review of the system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG noted leadership position turnover in the Quality Management Service as an area of vulnerability.

Executive leaders were very knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models. In individual interviews, leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[43] 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.[44]

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."[45] "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."[46]

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

- Emergency preparedness

- Supplies, equipment, and infrastructure

- Staffing

- Access to care

- CLC patient care and operations

- Vaccine administration

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

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

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

[45] 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). 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."

[46] 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.

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[47] 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.[48] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), 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."[49]

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

- Review of aggregated QSV data

- Recommendation and implementation of improvement actions

- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[50] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[51] The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator

- Tracking of facility-level performance improvement capability and projects

- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group

- Staff education on performance improvement principles and techniques

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[47] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[48] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

[49] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

[50] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

[51] VHA Directive 1026.01.

The OIG also assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[52] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[53] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[54] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)

- Peer review of all applicable deaths within 24 hours of admission to the hospital

- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[55]

- Completion of final reviews within 120 calendar days

- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[56]

- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

The VA Hudson Valley Health Care System did not have a surgical program; therefore, the OIG did not conduct a review of the surgical program requirements.

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes; systems redesign and improvement documents and reports; protected peer reviews; and other relevant information.[57]

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

[53] VHA Directive 1190.

[54] VHA Directive 1190.

[55] VHA Directive 1190.

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

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

Quality, Safety, and Value Findings and Recommendations

The healthcare system complied with most of the requirements listed above. However, the OIG identified a weakness with protected peer reviews.

VHA requires the Director to ensure that final peer reviews are completed within 120 calendar days from the determination that a review is needed and any requests for extensions be in writing and approved by the Director.[58] The OIG found that from June 1, 2020, through May 31, 2021, 6 of 14 peer reviews were not completed within the expected time frame and had no prior written extension approved by the Director. This likely prevented timely implementation of corrective actions to improve the quality of care provided at the healthcare system. Two of the peer reviews had an extension letter; however, both exceeded 120 days and were closed at the time the letter was generated and signed. The Patient Safety Manager reported that four people had served in the risk management position during the previous year. Additionally, the Patient Safety Manager explained that the prior Risk Manager was in the role for a year and had not been clear on the peer review designation letter process. According to the Chief of Staff, the Risk Manager also had a backlog of peer review cases.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that final peer reviews are completed within 120 calendar days or have a written extension request approved by the Director.

Healthcare system concurred.

Target date for completion: July 31, 2022

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. The Risk Manager has a spreadsheet to monitor timeliness of completion of peer reviews. For all reviews not completed within 120 calendar days, a written extension request will be made and signed by the Director. The Risk Manager will report findings quarterly to the Quality Safety Value Committee (QSV) until 90% compliance is met for six consecutive months. The numerator is the number of peer reviews completed within 120 calendar days or have a written extension request approved by the Director. The denominator is the number of peer reviews completed.

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[58] VHA Directive 1190.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of RNs that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[59] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[60]

VA requires all RNs to hold at least one active, unencumbered license.[61] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[62] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[63] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[64]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 10 RNs hired from July 1, 2020, through May 9, 2021. The OIG determined whether

- the RNs were free from potentially disqualifying licensure actions, or

- the Chief, Human Resources Management Service or Regional Counsel determined that the RNs met VA licensure requirements.

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[59] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. VHA Directive 2012 030 was replaced on September 15, 2021, by VHA Directive 1100.20, *Credentialing of Health Care Providers*. The two documents contain similar language regarding credentialing procedures.

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

[61] VHA Directive 2012-030, replaced by VHA Directive 1100.20. The two documents contain similar language regarding RN licenses. "Definition of *Unencumbered license,*" Law Insider, accessed December 3, 2020, https://www.lawinsider.com/dictionary/unencumbered-license. An unencumbered license is "a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action."

[62] 38 U.S.C. § 7402.

[63] VHA Directive 2012-030, replaced by VHA Directive 1100.20. The two documents contain similar language regarding RN licenses.

[64] VHA Directive 2012-030, replaced by VHA Directive 1100.20. The two documents contain similar language regarding RN licenses.

The OIG also reviewed the RNs' credentialing files to determine whether health care system staff completed primary source verification prior to the appointment.

Registered Nurse Credentialing Findings and Recommendations

The OIG found that RNs hired by the healthcare system between July 1, 2020, and May 9, 2021, were free from potentially disqualifying licensure actions. However, the OIG found a deficiency with the completion of primary source verification prior to appointment.

VHA requires the Director to ensure that "all licenses including not only current licenses, but all previously held, must be verified through primary source verification," prior to initial appointment.[65] The OIG found that 2 of 10 RN credentialing files reviewed had documentation of primary source verification, but the verification was not completed within the required time frame. Failure to verify each nursing license in the required time frame may have resulted in the inappropriate hiring of nurses, which could subsequently affect the provision of quality care. The Credentialing and Privileging Program Manager explained that previously, primary source verification was completed only for the licenses identified by the RN. Following VISN communication in December 2020, Credentialing and Privileging Department staff conducted an internal audit to identify previously unverified RN licenses requiring primary source verification.

The OIG found that two RN licenses not primary source verified within the required time frame were identified by healthcare system staff during the internal audit. Since the healthcare system demonstrated sustained compliance with timely primary source verifications for nurses hired after December 2020, the OIG made no recommendations.

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[65] VHA Directive 2012-030.

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[66] 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.[67] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[68]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[69] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[70] The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

- Completion of suicide safety plans by required staff

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

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

- relevant documents;

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[66] "Suicide Prevention: Facts About Suicide," Centers for Disease Control and Prevention, accessed October 8, 2021, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

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

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

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

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

- the electronic health records of 42 randomly selected patients who were seen in the urgent care center from December 1, 2019, through August 31, 2020; and

- staff training records.[71]

Mental Health Findings and Recommendations

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

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[71] The VA Hudson Valley Health Care System does not have an emergency department.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[72]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients."[73] Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[74]

The healthcare system was assessed for its adherence to various requirements:

- Existence of a facility policy for inter-facility transfers

- Monitoring and evaluation of inter-facility transfers

- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer

- Transmission of patient's active medication list and advance directive to the receiving facility

- Communication between nurses at sending and receiving facilities

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 42 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with requirements for the use of the VA *Inter-Facility Transfer Form* or a facility-defined equivalent by the appropriate providers and monitoring and evaluation of inter-facility transfers. However, the OIG identified deficiencies with the establishment of a facility policy for inter-facility transfers, completion of required transfer form

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

[73] VHA Directive 1094.

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

elements, transmission of patients' active medication lists and advance directives to receiving facilities, and nurse-to-nurse communication between facilities.

VHA requires the Director or designee ensure that a written policy is in place for "the safe, appropriate, orderly, and timely transfer of patients."[75] The Deputy Chief of Staff reported that the healthcare system used the national directive and did not have a local policy for inter-facility patient transfers. Failure to maintain a current inter-facility transfer policy could result in lack of coordination between facilities to provide seamless care for patients through the transfer process. The Deputy Chief of Staff also reported that based on VHA Notice 2020-034, *Mandatory Business Rules for Local Policy Development,* the healthcare system was decreasing the number of local policies and used national directives when possible.[76]

Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that a written policy is in place to ensure the safe, appropriate, orderly, and timely transfer of patients.

Healthcare system concurred.

Target date for completion: July 31, 2022

Healthcare system response: The reasons for noncompliance were considered when developing the action plan to ensure the presence of a facility written policy for Interfacility Transfers. The Director's designee determined the facility was using VHA Directive 1094 Inter-Facility Transfer Policy dated January 11, 2017 as their guide. The Chief of Staff will ensure creation of the facility specific policy for Inter-Facility Transfers by January 15, 2022.

VHA requires that the Chief of Staff ensure referring physicians record the identification of the receiving physicians on the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the patient's electronic health record.[77] The OIG estimated that transferring providers did not identify the receiving physician on 24 percent of inter-facility transfer notes.[78] This deficiency could result in the unsafe transfer of patients to other healthcare facilities. The Deputy Chief of Staff reported believing the requirement was met by documenting the receiving facility name or department, but acknowledged that more thorough documentation was necessary for proper handoff and patient safety.

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[75] VHA Directive 1094.

[76] VHA Notice 2020-034, *Mandatory Business Rules for Local Policy Development*, October 20, 2020.

[77] VHA Directive 1094.

[78] The OIG estimated that 95 percent of the time, the true compliance rate is between 62.8 and 88.6 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the referring physician includes all required elements on the VA *Inter-Facility Transfer Form* or facility-defined equivalent note in the patient's electronic health record.

Healthcare system concurred.

Target date for completion: July 31, 2022

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. The Chief of Staff in collaboration with the Associate Director for Patient Care Services (ADPCS) will ensure that all relevant staff including Providers receive training to complete all required elements on the VA Inter-Facility Transfer Form 10-2649A located in the transfer note, and to send all pertinent medical records with the patient during the Inter-Facility Transfer. The available CPRS [Computerized Patient Record System] template will be used to ensure all required elements of the transfer form are met. The Clinical Applications Coordinators (CAC) will ensure the template is available for use at the facility. The Patient Transfer Officer will conduct audits of completed transfers to validate that the referring physician includes all required elements on the VA Inter-Facility Transfer Form or facility-defined equivalent note in the electronic health record. Compliance with completion of the form/equivalent note will be monitored until there is 90% compliance for 6 consecutive months. The compliance will be reported to the Healthcare Delivery Council (HDC) on a quarterly basis. The numerator is the number of charts compliant with a completed transfer form/equivalent note. The denominator is the number of transfers. Compliance will be submitted to the VISN Quality Safety Value Committee quarterly.

Additionally, VHA requires the Chief of Staff and ADPCS to ensure that staff send all pertinent medical records with the patient during inter-facility transfers. This includes an active patient medication list and advance directive, when applicable.[79] The OIG estimated that 24 percent of electronic health records lacked evidence that staff sent an active medication list to the receiving facility.[80] Further, the OIG found that of the nine patients who had an advance directive, staff did not send a copy to the receiving facility for six patient transfers. Failure to send pertinent medical records could result in incorrect treatment decisions that compromise patient safety. Additionally, failure to send the advance directive could result in receiving facility staff being unable to determine patient preferences regarding their health care. The Deputy Chief of Staff explained that the medication list was documented in nursing notes but not in the physician notes

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[79] VHA Directive 1094.

[80] The OIG estimated that 95 percent of the time, the true compliance rate is between 62.5 and 88.4 percent, which is statistically significantly below the 90 percent benchmark.

that were sent to the receiving facility. The Deputy Chief of Staff also reported that this was found during an audit and corrected prior to the CHIP visit.

The Deputy Chief of Staff reported multiple factors that contributed to the advance directive not being sent to the receiving facility. These factors included the lack of immediate availability of the advance directive (despite the OIG finding evidence of an advance directive in the electronic health record), miscommunication between administrative and clinical staff regarding transfer paperwork expectations and processes, and the transfer form template defaulting to the no advance directive option.

Recommendation 4

4. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure staff send pertinent medical records to the receiving facility during inter-facility transfers.

Healthcare system concurred.

Target date for completion: July 31, 2022

Healthcare system response: The Chief of Staff and ADPCS will ensure that Health Administration Services staff (HAS) check that VA Inter-Facility Transfer Form, Advance Directives, and active Medication List are located and transferred with the patient. The Patient Transfer Officer will audit compliance with the tracking of this improvement action until 90% compliance is met for 6 consecutive months with progress reported to the Facility Chief of Staff at the monthly HDC. Compliance will be submitted to VISN Quality Safety Value Committee quarterly. The numerator is the number of charts compliant with the medication list and the advance directives, compliance determined separately, not combined. The denominator is the number of transfers.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at both sending and receiving facilities.[81] The OIG did not find evidence of this communication in an estimated 55 percent of electronic health records.[82] This could result in staff at the receiving facility lacking the information needed to care for patients. The Associate Chief, Nurse Ambulatory Care stated that nurses documented providing a patient report to the paramedics transporting the patient and attributed noncompliance to a lack of oversight.

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[81] VHA Directive 1094.

[82] The OIG estimated that 95 percent of the time, the true compliance rate is between 30.4 and 60.5 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 5

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

Healthcare system concurred.

Target date for completion: July 31, 2022

Healthcare system response: The ADPCS will ensure oversight of nurse-to-nurse communication between the sending and receiving facilities. The sending nurse must document in the VA 10-10 Handoff Form the name and title of the receiving nurse or designated nurse taking the report in the receiving facility. The Patient Transfer Officer will conduct audits to validate that nurse-to-nurse communication has been documented in the transfer record. Compliance with the tracking of this improvement action of 90% is monitored for 6 consecutive months with progress being reported to Facility Chief of Staff monthly in the HDC. Compliance will be submitted to VISN Quality Safety Value Committee quarterly. The numerator is the number of charts compliant with nurse-to-nurse communication on the transfer form. The denominator is the number of transfers.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[83] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[84] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior

- Implementation of an employee threat assessment team[85]

- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[86]

- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[87]

- Patient notification of an Order of Behavioral Restriction

- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[88]

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

[84] VHA Directive 2012-026.

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

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

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

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[89] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[90] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG found the healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with staff training.

VHA requires members of the Employee Threat Assessment Team to complete specific workplace violence prevention program trainings.[91] The OIG found that 8 of 9 Employee Threat Assessment Team members did not complete required trainings. Lack of training may result in failure to recognize, evaluate, and manage the risk of future violence. The Employee Threat Assessment Team Chair reported believing that training had been completed but, during the OIG review, realized a required field in a document used to report training was incorrectly completed, causing staff to overlook the lack of training.

Recommendation 6

6. The System Director evaluates and determines any additional reasons for noncompliance and ensures Employee Threat Assessment Team members complete required trainings.[92]

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

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

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

[92] The System Director is referred to as the Medical Center Director in the action plans below.

Healthcare system concurred.

Target date for completion: July 1, 2022

Healthcare system response: Medical Center Director (MCD) will ensure compliance with the VISN action plan to meet 90% compliance. The VISN 2 Network Mental Health Lead working with the VISN 2 Network Designated Learning Officer (DLO) will publish monthly Employee Threat Assessment Team (ETAT) training compliance reports. Compliance will be communicated with facility MCD via the VISN 2 Action Tracker. The numerator is the number of ETAT members trained. The denominator is the number of ETAT members. The MCD or designee will report with updated monthly action plans if 90% threshold is not met for six consecutive months. This new reconciliation process will go into effect January 2022.

VHA requires employees to complete prevention and management of disruptive behavior training based on the risk level assigned to their work areas."[93] The OIG found 7 of 30 employees reviewed (23 percent) had not completed the required trainings based on the risk level for their work areas. This could result in employees' lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Training Specialist/Prevention and Management of Disruptive Behavior Coordinator reported that trainings were not being scheduled due to COVID-19 restrictions.

Recommendation 7

7. The System Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[94]

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

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

Healthcare system concurred.

Target date for completion: July 1, 2022

Healthcare system response: Prevention and Management of Disruptive Behavior classes resumed in August of 2021. The Chief of Education announced at Leadership huddle the resumption of classes. The list of those employees who have not taken the required training based on risk level was shared with their supervisor. Training classes to obtain additional instructors resulted in a total of 18 instructors to provide training. Medical Center Director (MCD) will ensure compliance with the VISN action plan to meet 90% compliance. The VISN 2 Network Mental Health Lead working with the VISN 2 Network Designated Learning Officer (DLO) will publish monthly Prevention and Management of Disruptive Behaviors (PMDB) training compliance reports. Compliance will be communicated with the facility MCD via the VISN 2 Action Tracker. The numerator is the number of staff who completed the PMDB training at the required level. The denominator is the number of staff required to attend. The MCD or designee will report with updated monthly action plans if 90% threshold is not met for six consecutive months. This new reconciliation process will go into effect January 2022.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

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

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews	• Final peer reviews are completed within 120 calendar days or have a written extension request approved by the Director.	• None
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• Staff send pertinent medical records to the receiving facility during inter-facility transfers. • Nurse-to-nurse communication occurs between sending and receiving facilities.	• A written policy is in place to ensure the safe, appropriate, orderly, and timely transfer of patients. • Referring physicians include all required elements on the VA *Inter-Facility Transfer Form* or facility-defined equivalent note in the patient's electronic health record.

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

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 2.[1]

Table B.1. Profile for VA Hudson Valley Health Care System (620)
(October 1, 2017, through September 30, 2020)

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019[†]	Healthcare System Data FY 2020[‡]
Total medical care budget	$274,421,988	$232,224,240	$265,008,851
Number of:			
• Unique patients	23,780	23,258	21,746
• Outpatient visits	370,230	361,474	298,586
• Unique employees[§]	1,015	1,025	998
Type and number of operating beds:			
• Community living center	297	297	297
• Domiciliary	148	104	104
• Intermediate	12	–	–
• Medicine	15	15	15
• Mental health	105	30	30
• Spinal cord	0	0	0

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

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019	Healthcare System Data FY 2020‡
Average daily census:			
• Community living center	89	104	97
• Domiciliary	90	82	61
• Medicine	5	3	3
• Mental health	21	12	8

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

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

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
New City, NY	620GA	3,257	953	Endocrinology Eye Hematology/ Oncology Nephrology Podiatry Poly-Trauma Rehab physician	EKG Nuclear medicine	Nutrition Pharmacy Social work Weight management

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Carmel, NY	620GB	1,856	652	Endocrinology Eye Hematology/ Oncology Nephrology Neurology Podiatry Poly-Trauma Rehab physician	EKG	Nutrition Pharmacy Social work Weight management
Goshen, NY	620GD	3,423	838	Eye Hematology/ Oncology Nephrology Neurology Podiatry Poly-Trauma	EKG	Nutrition Pharmacy Social work Weight management
Port Jervis, NY	620GE	2,613	391	Endocrinology Eye Hematology/ Oncology Neurology Podiatry Poly-Trauma Rehab physician	EKG	Nutrition Pharmacy Prosthetics Social work Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Monticello, NY	620GF	1,762	185	Endocrinology Eye Hematology/ Oncology Podiatry Poly-Trauma Rehab physician	EKG	Nutrition Pharmacy Social work Weight management
Poughkeepsie, NY	620GG	2,204	260	Endocrinology Eye Hematology/ Oncology Nephrology Podiatry Poly-Trauma Rehab physician	EKG	Nutrition Pharmacy Social work Weight management
Pine Plains, NY	620GH	648	22	Endocrinology Eye Hematology/ Oncology Podiatry Rehab physician	EKG	Nutrition Pharmacy Social work

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

	All VHA	(620) Montrose, NY (Franklin Delano Roosevelt)	(620A4) Castle Point, NY	(620GA) New City, NY	(620GB) Carmel, NY	(620GD) Goshen, NY	(620GE) Port Jervis, NY	(620GF) Monticello, NY	(620GG) Poughkeepsie, NY	(620GH) Eastern Dutchess, NY
APR-FY20	3.6	0.0	1.7	0.0	0.0	13.5	0.0	0.0	0.0	0.0
MAY-FY20	4.0	0.0	4.1	n/a	n/a	0.0	n/a	n/a	0.0	n/a
JUN-FY20	4.9	0.1	0.8	7.0	0.0	1.1	10.5	0.0	n/a	n/a
JUL-FY20	5.9	1.5	3.1	0.0	0.0	1.2	21.0	11.0	3.5	n/a
AUG-FY20	5.6	1.1	4.2	11.5	0.0	6.1	12.3	0.0	2.0	n/a
SEP-FY20	6.1	0.6	2.3	2.9	2.2	2.5	0.5	1.3	3.1	0.0
OCT-FY21	6.3	0.9	2.3	2.3	0.1	2.3	2.2	0.0	1.6	3.5
NOV-FY21	6.7	0.5	3.9	0.1	0.0	0.0	3.7	0.2	3.2	1.8
DEC-FY21	6.6	1.8	2.7	1.7	0.0	0.2	5.5	1.0	0.0	0.0
JAN-FY21	4.4	1.5	0.7	0.9	0.0	0.0	1.3	1.3	1.7	0.5
FEB-FY21	2.9	2.6	4.8	1.9	0.3	2.3	2.6	9.7	6.6	1.3
MAR-FY21	2.9	1.8	1.5	0.4	0.8	3.1	2.0	3.7	3.3	2.1

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

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

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

Quarterly Established Primary Care Patient Average Wait Time in Days

Number of Days

15.0 — 10.0 — 5.0 — 0.0

	All VHA	(620) Montrose, NY (Franklin Delano Roosevelt)	(620A4) Castle Point, NY	(620GA) New City, NY	(620GB) Carmel, NY	(620GD) Goshen, NY	(620GE) Port Jervis, NY	(620GF) Monticello, NY	(620GG) Poughkeepsie, NY	(620GH) Eastern Dutchess, NY
APR-FY20	1.9	0.1	1.2	0.4	0.0	1.4	0.2	0.0	0.0	0.0
MAY-FY20	2.1	0.1	2.2	0.3	0.3	0.5	0.2	0.2	0.6	0.4
JUN-FY20	3.7	0.6	1.8	2.6	1.8	2.6	2.2	0.5	4.3	0.3
JUL-FY20	5.1	1.2	2.1	4.1	2.2	4.3	1.8	0.8	1.3	3.6
AUG-FY20	5.0	2.6	4.6	7.1	1.9	6.2	0.6	2.4	1.5	1.4
SEP-FY20	4.9	1.9	2.8	4.6	0.7	3.1	1.4	1.5	1.3	0.8
OCT-FY21	5.0	2.1	3.6	3.1	2.5	3.6	3.2	1.9	4.3	1.8
NOV-FY21	5.2	5.3	7.9	9.3	0.3	6.2	3.5	5.3	2.6	4.3
DEC-FY21	5.2	4.4	8.8	4.1	0.3	6.6	6.3	6.4	2.9	5.0
JAN-FY21	4.0	7.1	11.8	2.5	1.5	12.5	6.5	3.3	5.6	10.8
FEB-FY21	3.1	9.3	8.6	9.2	0.2	7.8	7.5	3.7	6.5	5.1
MAR-FY21	3.5	12.4	6.5	5.2	0.4	8.1	2.3	2.9	3.7	6.3

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

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

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

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use engmt	Sharing and use of All Employee Survey (AES) data	A higher value is better than a lower value
Behavioral health (BH90)	Healthcare Effectiveness Data and Information Set (HEDIS) outpatient performance measure composite related to screening for depression, posttraumatic stress disorder, alcohol misuse, and suicide risk	A higher value is better than a lower value
Care transition (HCAHPS)	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
Diabetes (DMG90_ec)	HEDIS outpatient performance measure composite for diabetes care	A higher value is better than a lower value
ED throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Healthcare associated infections	A lower value is better than a higher value
Hospital rating (HCAHPS)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Inpt global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value

Measure	Definition	Desired Direction
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	A higher value is better than a lower value
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH population coverage	Mental health population coverage	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
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	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 PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value

Measure	Definition	Desired Direction
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH survey)	A higher value is better than a lower value
Tobacco & cessation (SMG90_1)	HEDIS outpatient performance measure composite related to tobacco screening and cessation strategies	A lower value is better than a higher value

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: 12/22/2021

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subj: Comprehensive Healthcare Inspection of the VA Hudson Valley Health Care System in Montrose, New York

To: Director, Office of Healthcare Inspections (54CH03)

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

Thank you for the opportunity to review the OIG draft report, Comprehensive Healthcare Inspection of the VA Hudson Valley Health Care System in Montrose, New York. I concur with the report findings and recommendations.

(Original signed by:)

Joan E. McInerney, MD, MBA, MA, FACEP
Network Director, VISN 2

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: 12/17/2021

From: Director, VA Hudson Valley Health Care System (620/00)

Subj: Comprehensive Healthcare Inspection of the VA Hudson Valley Health Care System in Montrose, New York

To: Director, New York/New Jersey VA Health Care Network (10N2)

I have reviewed the attached Draft Report for the CHIP Review of the VA Hudson Valley Health Care System, Montrose, New York and concur with this report.

I have reviewed the action plans and concur with them as submitted. VA Hudson Valley Health Care System will continue to monitor and report as required.

(Original signed by:)

Dawn Schaal

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