DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the James J. Peters VA Medical Center in Bronx, New York

CHIP REPORT | REPORT #21-00289-90 | MARCH 3, 2022

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Figure 1. *James J. Peters VA Medical Center in Bronx, New York.*
Source: https://www.va.gov/bronx-health-care/locations/james-j-peters-department-of-veterans-affairs-medical-center/ (*accessed June 15, 2021*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
PCMH	Patient-Centered Medical Home
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 James J. Peters VA Medical Center and related outpatient clinics in New York. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

The OIG conducted an unannounced virtual review of the James J. Peters VA Medical Center during the week of June 22, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings may help this medical center and other Veterans Health Administration (VHA) facilities identify

[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)."

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 five recommendations to the Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services/Chief Nurse Executive. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the medical center's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services/Chief Nurse Executive, and Associate Director. Organizational communications and accountability were managed through a committee reporting structure, with Quality Executive Board oversight of several working groups. The Director served as the chairperson of the Quality Executive 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 Performance Improvement Council, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's leaders had worked together for approximately eight months, although most had served in their positions for more than a year. The Associate Director for Patient Care Services/Chief Nurse Executive, permanently assigned in May 2010, was the most tenured leader. The Chief of Staff, assigned in October 2020, was the newest member of the leadership team and had previously served as the Chief of Primary Care for nearly four years. The Director and Associate Director had served in their positions since October 2019 and October 2017, respectively.

The medical center's fiscal year 2020 annual medical care budget increased approximately 6 percent compared to the previous year. The executive leaders were able to discuss interim strategies to address clinical and nonclinical shortages.

The OIG reviewed survey results and concluded that both the Associate Director and Associate Director for Patient Care Services/Chief Nurse Executive had opportunities to reduce staff

feelings of moral distress at work, while the Associate Director also had opportunities to improve servant leader behavior.[2]

Patient survey results indicated opportunities for leaders to improve patients' satisfaction in the inpatient setting and their ability to obtain appointments for routine and/or urgently needed care in patient-centered medical home and specialty care clinics.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and identified organizational risk factors associated with sentinel event and institutional disclosure processes.[3]

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."[4] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[5]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures. Leaders also demonstrated an understanding of Community Living Center SAIL measures.[6] In individual interviews, the executive leadership team members were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

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[2] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The 2020 All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing." The Servant Leader Index is a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns. Survey results were not reflective of employee satisfaction with the current Chief of Staff, who was not in the role when the survey was administered in September 2020.

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

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

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

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

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions and the Systems Redesign and Improvement Program. However, the OIG identified weaknesses in protected peer review and surgical work group processes.[7]

Medication Management

The OIG team observed compliance with many elements of expected performance, including the availability of staff to receive remdesivir shipments, completion of required testing prior to remdesivir administration, and reporting of adverse events. However, the OIG found deficiencies with the provision of patient or caregiver education.

Care Coordination

Generally, the medical center met expectations for the existence of an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, completion of the VA *Inter-Facility Transfer Form*, transmission of an active medication list, and communication between nurses at sending and receiving facilities.[8] However, the OIG noted that staff did not consistently send patients' advance directives to receiving facilities.

High-Risk Processes

The medical center met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with required members' attendance at Disruptive Behavior Committee meetings and staff training.

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

[8] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. (This directive was rescinded and replaced by VHA Directive 1094, *Inter-Facility Transfer*, January 20, 2022. The two documents contain similar language regarding the risks of patient transfers, but VHA removed the requirement for facilities to have a written policy.) 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.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued five recommendations for improvement to the Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services/Chief Nurse Executive. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use these recommendations to help guide improvements in operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Interim Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 60–61, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 1, 2, and 3 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 James J. Peters VA Medical Center and related outpatient clinics examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.[1]

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

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

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

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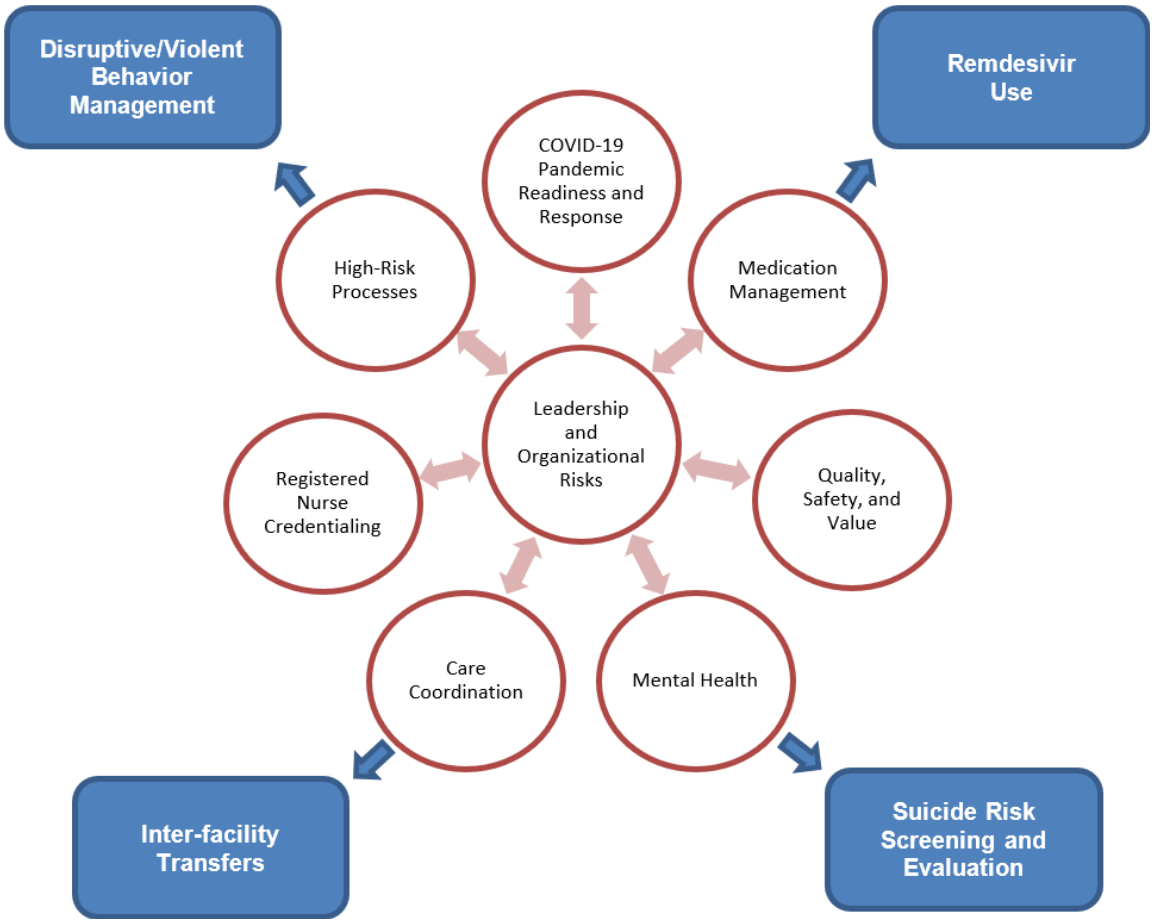


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*

Methodology

The James J. Peters VA Medical Center also provides care through multiple outpatient clinics in New York. Additional details about the types of care provided by the medical center can be found in appendixes B and C.

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

The inspection examined operations from April 29, 2017, through June 25, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[8] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect a healthcare system's ability to provide care in the clinical focus areas.[9] To assess this medical center's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the medical center response
8. VHA performance data (medical center)
9. VHA performance data (community living center (CLC))[10]

Executive Leadership Position Stability and Engagement

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

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

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

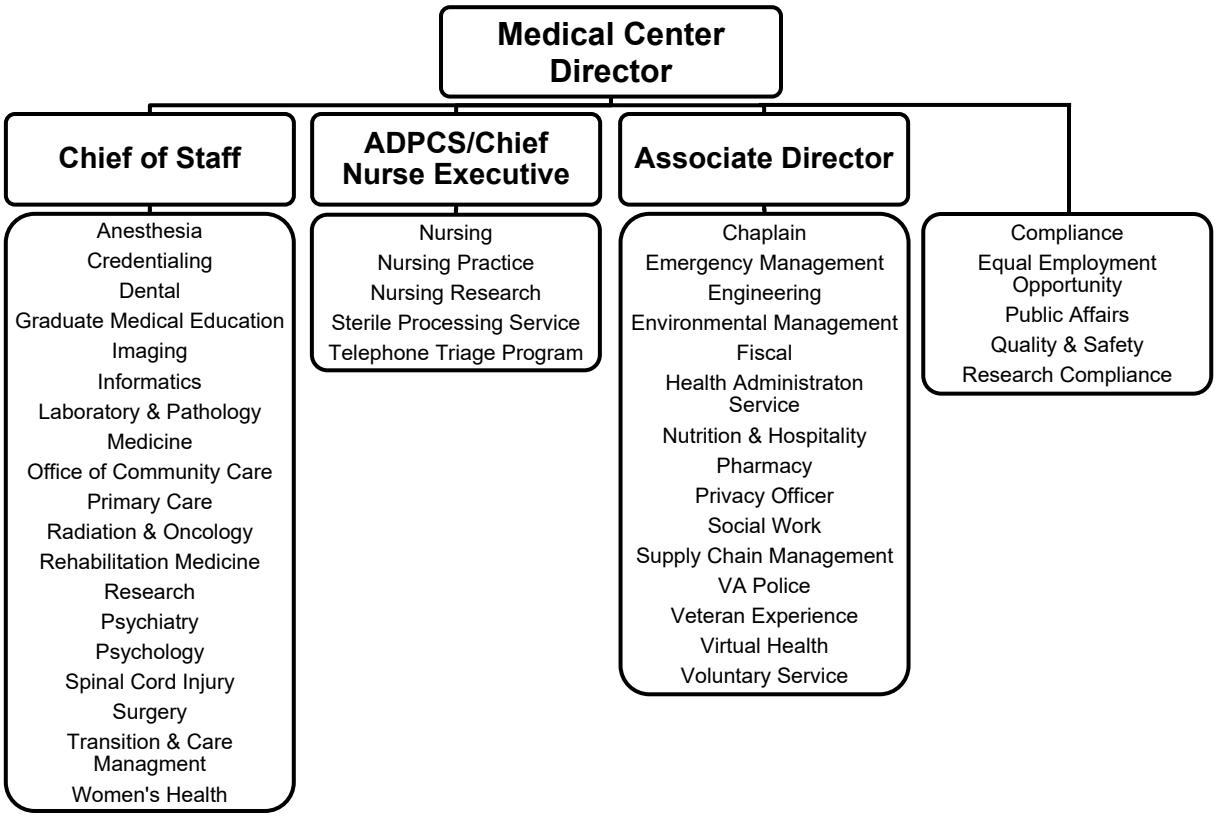


Figure 3. *Medical center organizational chart.*
Source: James J. Peters VA Medical Center (received June 22, 2021).

At the time of the OIG inspection, the executive team had worked together for approximately eight months, although most had served in their positions for more than a year. The ADPCS/Chief Nurse Executive, permanently assigned in May 2010, was the most tenured leader. The Chief of Staff, assigned in October 2020, was the newest member of the leadership team and had previously served as the Chief of Primary Care for nearly four years. The Director and Associate Director had served in their positions since October 2019 and October 2017, respectively (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	October 27, 2019
Chief of Staff	October 11, 2020
Associate Director for Patient Care Services/Chief Nurse Executive	May 23, 2010
Associate Director	October 29, 2017

Source: James J. Peters VA Medical Center Assistant Human Resources Officer, VISN Senior Strategic Business Partner (received June 22, 2021).

The Director served as the chairperson of the Quality Executive Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Board oversaw various working groups such as the Performance Improvement and Nursing Executive Inter-Practice Councils, and Medical Executive, Compliance, and Environment of Care Committees. These leaders monitored patient safety and care through the Performance Improvement Council, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

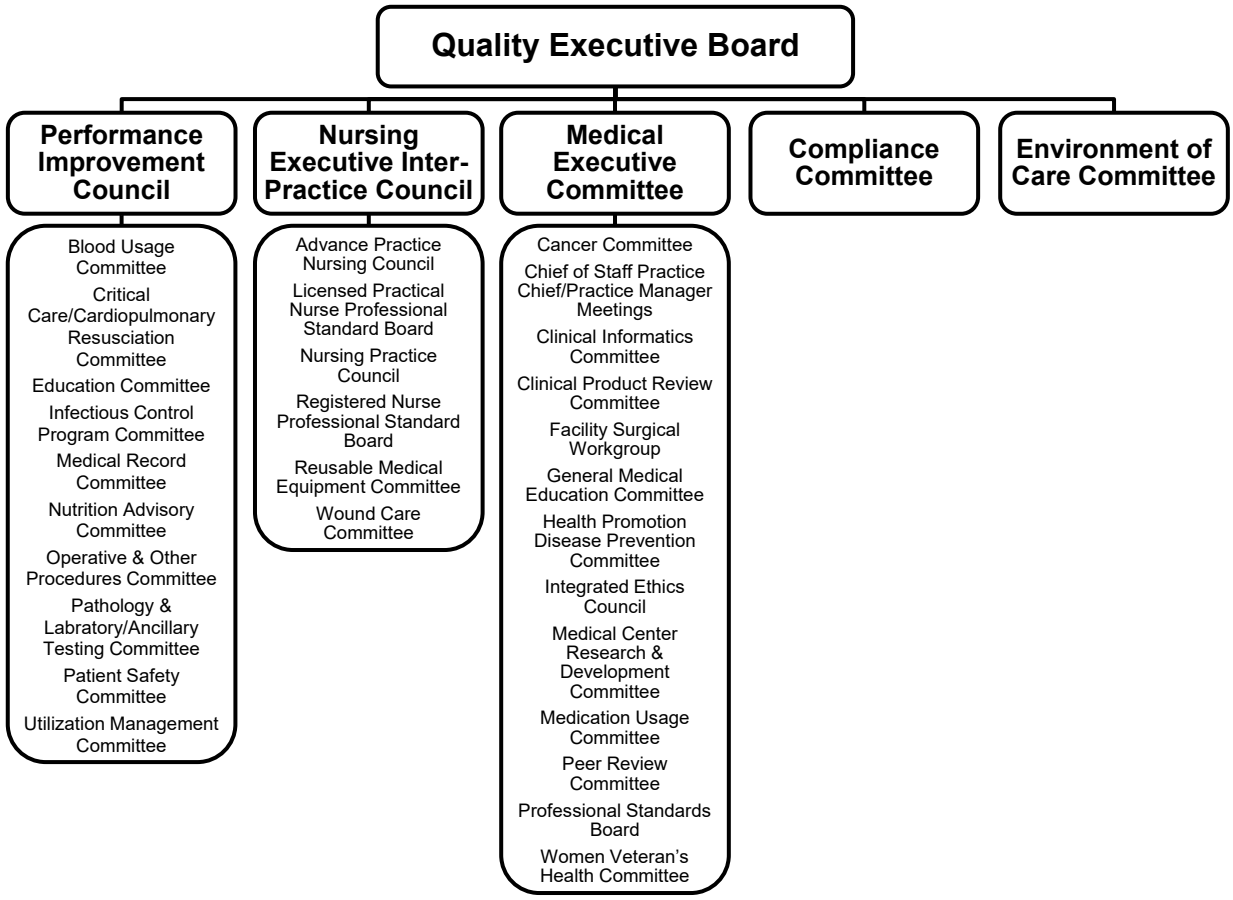


Figure 4. *Medical center committee reporting structure.*
Source: James J. Peters VA Medical Center (received June 23, 2021).

To help assess the medical center executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPCS/Chief Nurse Executive, and Associate Director regarding their knowledge of medical center operations, various performance metrics, and their involvement and support of actions to improve or sustain performance. In individual interviews, the executive leadership team members seemed well informed 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.

Budget and Operations

The medical center's FY 2020 annual medical care budget of $359,151,167 increased approximately 6 percent compared to the previous year's budget of $339,842,922.[11] When asked about the effect of this change on the medical center's operations, the Director indicated that the budget increase helped leaders improve infrastructure, purchase equipment, and hire more staff. For example, medical center leaders converted the majority of patient rooms to negative pressure rooms, added plumbing to acute care units for dialysis capability, purchased higher grade medical-surgical beds that could also be used in the intensive care unit, and hired additional staff (nurses and pharmacists) to support COVID-19 vaccination efforts.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[12] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[13] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[14] 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*.[15]

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Radiology–Interventional	1. General Engineering
2. Orthopedic Surgery	2. Medical Supply Aides and Technicians
3. Primary Care	3. Medical Records Technicians
4. Radiation Oncology	4. Pipefitting
5. RN Staff–Perioperative	5. Utility Systems Operators

Source: VA OIG.

[11] VHA Support Service Center.

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

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

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

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

At the time of the inspection, executive leaders reported successful recruitment of radiation oncologists and primary care physicians. However, the Director and Chief of Staff shared ongoing challenges with recruiting and retaining interventional radiologists, orthopedic surgeons, perioperative RNs, and licensed practical nurses. Leaders attributed recruitment challenges to the inability to compete with higher salary rates in the private sector. The executive team described ongoing efforts to address clinical occupational shortages that included

- conducting salary surveys,
- requesting salary increases,
- offering retention bonuses and relocation packages,
- providing employee debt reduction for student loans,
- recruiting from affiliated universities and local colleges,
- hiring fee-basis clinicians, and
- approving full-time remote work for qualified employees.

For nonclinical staffing shortages, executive leaders also discussed challenges recruiting and retaining engineers, technicians (medical supply and medical records), and trade workers (pipefitters and utility systems operators). The Director conveyed recent success in retaining existing engineers by offering retention bonuses and securing special salary rates. Additionally, the Director reported hiring five engineers who recently graduated and described plans for them to participate in an on-the-job training program with seasoned engineers.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[16] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[17] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through

[16] "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.)

[17] "AES Survey History."

September 30, 2020.[18] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. The OIG found that survey scores for the Chief of Staff and ADPCS/Chief Nurse Executive were higher than VHA averages.[19] However, the Director has opportunities to improve levels of motivation and commitment in the workforce and employees' perception of respect for senior leaders. An opportunity also exists for medical center leaders overall and specifically the Associate Director to improve employee perceptions of servant leader behavior.[20]

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

[19] The 2020 All Employee Survey results are not reflective of employee satisfaction with the current Chief of Staff, who assumed the role after the survey was administered.

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	69.7	83.3	81.2	92.2	65.8
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.4	3.3	3.9	4.1	3.7
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	3.7	4.1	4.0	3.8
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	3.5	4.1	4.1	4.0

Source: VA All Employee Survey (accessed May 19, 2021).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[21] Averages for the Director and Chief of Staff were better than VHA and

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

medical center averages.[22] However, the medical center overall, ADPCS/Chief Nurse Executive, and Associate Director have opportunities to reduce employee feelings of moral distress at work.

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	4.2	4.2	3.8	3.8
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	3.7	4.2	4.4	4.6	4.0
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	1.8	0.8	1.2	2.0	2.2

Source: VA All Employee Survey (accessed May 19, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[23] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop

[22] The 2020 All Employee Survey results are not reflective of employee satisfaction with the current Chief of Staff, who assumed the role after the survey was administered.

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

Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[24]

Executive leaders described demonstrating a commitment to a harassment-free health care environment by signing memorandums, hanging posters, providing staff training, and visiting employees in various work units to discuss ways to promote inclusion and tolerate differences. Additionally, the Director discussed recently hiring a new Equal Employment Opportunity Manager who was very engaged with staff and building a stronger program. Further, the Director reported chartering a new Diversity and Inclusion Committee and publishing a weekly electronic newsletter.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The executive leadership team averages for the selected survey questions were generally similar to or better than VHA averages; however, medical center averages were slightly lower.[25] Leaders appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.7	4.0	4.4	4.5	3.8
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	3.9	4.3	4.5	4.6	4.0
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.6	4.0	4.4	4.9	3.6

Source: VA All Employee Survey (accessed May 19, 2021).

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

[25] The 2020 All Employee Survey results are not reflective of employee satisfaction with the current Chief of Staff, who assumed the role after the survey was administered.

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (PCMH), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides survey results for VHA and the medical center.[26] For this medical center, respondents scored their specialty care experience higher than the VHA average but rated their inpatient and PCMH care lower. The Director and Chief of Staff attributed the lower inpatient scores to patient complaints about food, noise, and continuity of care. The Director reported introducing a new food menu, taking measures to reduce noise levels in the evening, and hiring a team of hospitalists to provide patient care 24 hours per day, 7 days per week. To address the lower PCMH scores, the Director and Chief of Staff described enhancing patient communication by requiring providers to answer patients' electronic secure messages within the same or next day and implementing an improved patient education plan.

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

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	60.4
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	79.9
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	87.2

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[27] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, PCMH, and Specialty Care surveys (see tables 7–9). Survey results revealed opportunities for leaders to improve satisfaction for both genders in inpatient and outpatient settings.

For inpatient care, the results for female respondents were generally more favorable than corresponding VHA averages, except for their perceptions of doctors treating them with courtesy and respect. Both the Director and Chief of Staff acknowledged the need to train physicians to improve communication with women veterans. Leaders also have opportunities to improve results related to male patients recommending the hospital to family and friends and their perceptions of nurses treating them with courtesy and respect. The Director attributed the low

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

scores to generational differences and stated that male patients generally listened more to their doctors.

In outpatient settings, survey results showed generally favorable PCMH experiences for both genders, except female patients' ability to obtain routine appointments. For specialty care, results indicated opportunities for leaders to improve male patients' ability to obtain appointments for routine or urgently needed care. The Director, Chief of Staff, and ADPCS/Chief Nurse Executive attributed the low patient experience scores to a small survey sample size and fewer face-to-face interactions due to the pandemic.

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

Questions	Scoring	VHA*		Medical Center	
		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	60.1	68.5
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	85.0	69.0
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	79.8	99.5

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 medical center averages are based on 312–316 male and 10 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	52.1	52.9
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	60.5	35.9
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	78.3	72.6

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

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

The medical center averages are based on 183–528 male and 17–29 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*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	40.6	51.2
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	53.3	63.3
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	75.6	82.4

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

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

The medical center averages are based on 248–607 male and 10–40 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[28] Table 10 summarizes the relevant medical center inspections most recently performed by the OIG and The

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

Joint Commission (TJC).[29] At the time of the OIG review, the medical center had closed all recommendations for improvement issued since the previous CHIP site visit conducted in April 2017. For TJC surveys conducted in April and May 2021, eight recommendations were open at the time of the virtual review because insufficient time had passed for implementation of corrective actions.

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities.[30] Additional results included the Long Term Care Institute's inspection of the medical center's CLC and Paralyzed Veterans of America's inspection of the spinal cord injury/disease unit and related services.[31]

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

[30] 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."

[31] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings." The Paralyzed Veterans of America inspection took place February 11, 2020. This veterans service organization review does not result in accreditation status.

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 James J. Peters VA Medical Center, Bronx, New York*, Report No. 17-01751-25, November 29, 2017)	April 2017	15	0
TJC Hospital Accreditation	April 2018	51	0
TJC Behavioral Health Care Accreditation		6	0
TJC Home Care Accreditation		12	0
TJC Laboratory	April 2021	1	1
TJC Behavioral Health Care and Human Services Accreditation	May 2021	7	7

Source: OIG and TJC (inspection/survey results received from the Director of Performance Improvement/Quality Management on June 23, 2021).

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

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

Table 11 lists the reported patient safety events from April 29, 2017 (the prior OIG CHIP site visit), through June 22, 2021.[32]

Table 11. Summary of Selected Organizational Risk Factors (April 29, 2017, through June 22, 2021)

Factor	Number of Occurrences
Sentinel Events	6
Institutional Disclosures	12
Large-Scale Disclosures	0

Source: James J. Peters VA Medical Center's Director of Performance Improvement and Patient Safety Officer (received July 6, 2021).

The Director spoke knowledgeably about serious adverse event reporting, explaining that the Performance Improvement Council is always involved in the process of determining whether to conduct a root cause analysis and/or peer review.[33] The Director discussed a collaborative decision-making process with the Patient Safety Manager to determine when an institutional disclosure is warranted.

Based on the challenges of obtaining timely and complete information, the OIG identified opportunities for leaders to improve tracking and documentation of sentinel events and institutional disclosures, and ensure root causes are analyzed and improvement efforts are implemented to prevent reoccurrence. The Director acknowledged that the Director of Performance Improvement was managing too many processes and reported taking steps toward

[32] 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 James J. Peters VA Medical Center is a high complexity (1b) 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."

[33] According to the Director, the Performance Improvement Council will be renamed the Quality Safety and Value Committee.

reorganizing the service. Specifically, the Director discussed plans to hire additional staff and focus more on improving processes.

The OIG identified a trend of adverse events involving surgical procedures that included four postoperative deaths that occurred since the last OIG CHIP visit. During interviews, the Director reported meeting with the National Surgery Office to address the identified surgical issues. In response to the National Surgery Office's recommendation, the VISN 2 Chief Surgical Consultant conducted a site visit to identify potential areas for improvement of perioperative patient care and recommend quality improvement processes. On January 9, 2020, the consulting surgeon concluded in a report that most cases of postoperative deaths involved patients deemed to be at high risk for the surgeries performed because of their underlying medical conditions. Generally, the consulting surgeon did not identify significant deficiencies in the surgical care provided at the medical center. However, the surgeon detected a systems issue with timely reading of the electrocardiogram for one surgical procedure and noted that medical center leaders promptly identified and addressed it.

The OIG noted additional surgical issues following the January 2020 report involving postoperative complications and death. During interviews, the Director and Chief of Staff described creating a task force to implement an ongoing and enhanced perioperative review process. By July 2021, surgical service staff reported two surgical deaths over a six-month period, which was a reduction of approximately 50 percent as compared to the previous six months. Both leaders stated and provided evidence that showed marked improvement in surgical mortality and morbidity data.

The OIG also identified opportunities for leaders to improve sentinel event and institutional disclosure tracking processes as well as the medical center's surgical program. Leaders shared plans to reorganize the Performance Improvement Council and provided evidence of an enhanced perioperative review process with improved outcome measures.

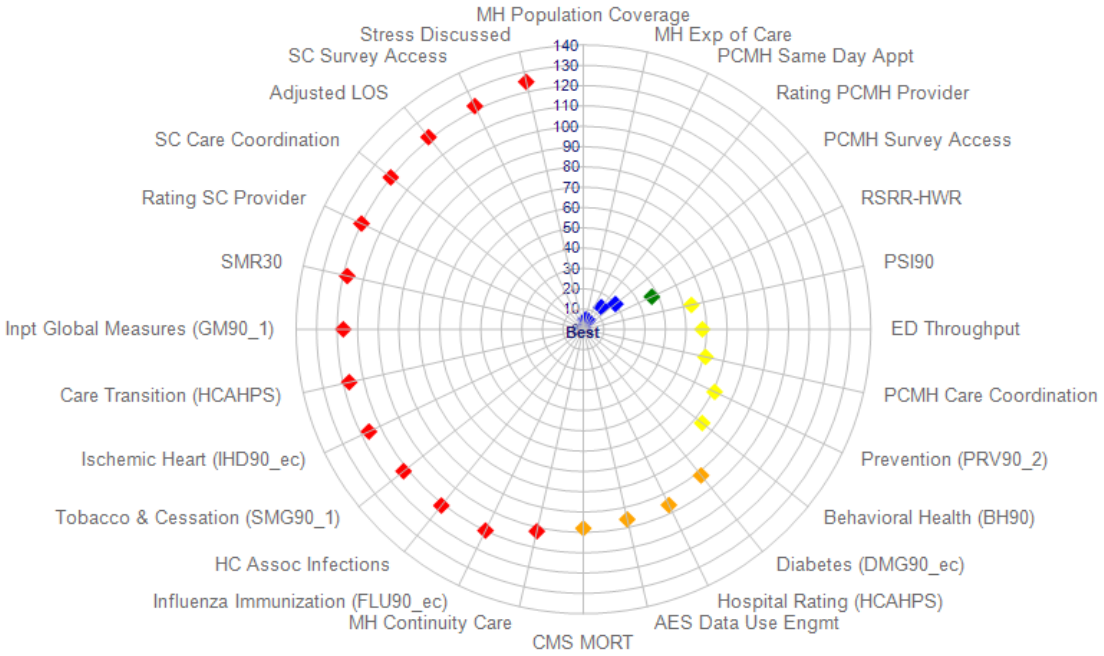
Veterans Health Administration Performance Data for the Medical Center

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."[34] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[35]

[34] "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.)

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

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the medical center's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, mental health (MH) population coverage, PCMH same day appointment (appt), and hospital-wide readmission (RSRR-HWR)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, All Employee Survey (AES) data use engagement (engmt), health care (HC) associated (assoc) infections, and adjusted length of stay (LOS)).[36] The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures.



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

Figure 5. *Medical center 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.

[36] 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."[37] 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."[38]

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. Figure 6 displays the CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, catheter in bladder–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and urinary tract infection (UTI) (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, high risk PU (LS), moderate-severe pain (SS), and ability to move independently worsened (LS)).[39] The executive leaders demonstrated an understanding of specific CLC SAIL measures and factors contributing to metrics that need improvement.

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

[38] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks*. "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

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

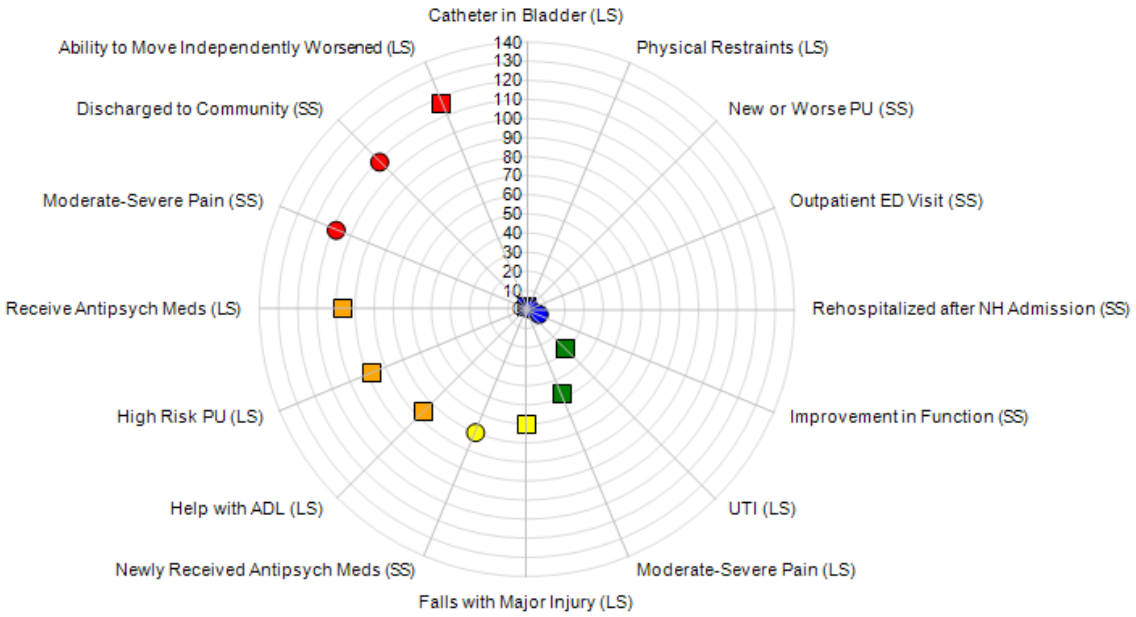


Figure 6. *Medical center CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).*

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 eight months, although most had been in their positions for more than a year. The ADPCS/Chief Nurse Executive was the most tenured leader, while the Chief of Staff, appointed in October 2020, was the newest member of the leadership team but had previously served as the medical center's Chief of Primary Care for nearly four years. The Director and Associate Director had served in their positions since October 2019 and October 2017, respectively.

The Director served as the chairperson of the Quality Executive Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The medical center's FY 2020 annual medical care budget increased approximately 6 percent compared to the previous year, and the executive leaders were able to discuss interim strategies to address clinical and nonclinical shortages.

Selected employee satisfaction survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated. However, survey results also pointed to opportunities for the Associate Director to improve servant leader behavior and for the ADPCS/Chief Nurse Executive and Associate Director to

reduce employee feelings of moral distress at work. Patient survey results indicated opportunities for leaders to improve patient satisfaction in the inpatient setting and their ability to obtain routine and/or urgently needed appointments in outpatient PCMH and specialty care clinics.

The leadership team was knowledgeable within their scope of responsibility about medical center and CLC SAIL measures but should continue to take actions to improve and sustain performance.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures identified organizational risk factors. Specifically, the OIG noted concerns with adverse events related to surgical procedures but confirmed that medical center leaders took measures to prevent future similar events. In addition, the OIG noted an opportunity for leaders to improve tracking and documentation of sentinel events and institutional disclosures. Because leaders had implemented corrective actions, such as creating a surgical task force to enhance the perioperative evaluation process, 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.[40] 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.[41]

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."[42] "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."[43]

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

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

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

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

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[40] "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.

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

[42] 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 "[p]rovision 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."

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[44] 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.[45] 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."[46]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center's committee responsible for 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 medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[47] 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."[48] 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

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

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[49] 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."[50] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[51] 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[52]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[53]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[54] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities;

[49] 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."

[50] VHA Directive 1190.

[51] VHA Directive 1190.

[52] VHA Directive 1190.

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

[54] "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, https://dvagov.sharepoint.com/sites/VHANSOVASQIP/SitePages/Default.aspx. (This is an internal VA website not publicly accessible.)

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[55] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (RN)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[56]

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

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions and the Systems Redesign and Improvement Program. However, the OIG identified weaknesses in protected peer review and surgical work group processes.

VHA requires an executive-level medical committee to review summaries of the Peer Review Committee's analyses on a quarterly basis.[58] The OIG found that from April 2020 through March 2021, the Peer Review Committee did not provide a summary report to the Medical Executive Committee for two quarters. Inconsistent reviews of quarterly summary reports may prevent the Medical Executive Committee from identifying clinical practice trends, determining the need for further action, and monitoring the effectiveness of quality improvement initiatives. The Risk Manager and Chief of Staff stated that the Medical Executive Committee did not meet when the Peer Review Committee was scheduled to present two quarterly summary reports due to the pandemic.

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

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

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

[58] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Peer Review Committee submits a quarterly summary analysis for review by the Medical Executive Committee.[59]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Chief of Staff evaluated the reasons for non-compliance and determined there were no additional reasons for non-compliance. Due to COVID 19 pandemic, the Medical Executive Committee (MEC) did not meet when Peer Review Committee (PRC) quarterly reports were due to be presented for Q1 and Q2. The peer review committee quarterly reports were presented in June 2021 (Q2 FY21 report), August 2021 (Q3 FY21 report), October 2021 (Q4 FY21 report), and January 2022 (Q1 FY22). Quality Management Staff audited the MEC minutes and verified documentation of the PRC Quarterly Reports were presented.

Expected Compliance: A target of 90% or greater compliance was achieved for six consecutive months from June 2021 to January 2022. PRC quarterly reports to the MEC are included as a standing agenda item. Quality Management staff will continue to audit MEC minutes for PRC Quarterly Reports for an additional two quarters to ensure sustainability and report compliance to the Quality Safety Value (QSV) committee.

VHA requires medical facility directors to ensure that facilities with surgery programs have a surgical work group.[60] VHA requires the surgical work group to meet monthly and include the Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as members.[61] The OIG interviewed key staff, reviewed Facility Surgical Workgroup meeting minutes from April 1, 2020, through March 31, 2021, and found that the Chief of Staff did not attend any of the meetings and the Operating Room Nurse Manager did not attend two meetings.[62] The lack of core members' attendance may have resulted in the review and analysis of surgery program data without the perspectives of key staff. The Chief of Surgery and Chief of Staff cited competing priorities as the reason for missed attendance. Additionally, the Chief of Surgery stated that the Operating Room Nurse Manager was deployed in support of federal

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

[60] VHA Directive 1102.01(1).

[61] VHA Directive 1102.01(1).

[62] The Chief of Surgery reported that the Facility Surgical Workgroup meeting was cancelled in August 2020 because several members were reassigned to support clinical areas managing COVID-19 patients; therefore, there were eleven required meetings during the review period.

COVID operations, and the designee who covered operating room duties was not aware of meeting attendance responsibilities.

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that required members attend Facility Surgical Workgroup meetings.[63]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Medical Center Director evaluated the reasons for non-compliance and determined there were no additional reasons for non-compliance for non-attendance of Chief of Staff and OR nurse manager as core members consistently. During the Chief of Staff transition, the incoming Chief of Staff was not included in the meeting invitation due to oversight. The Surgical Work Group (SWG) continues to meet on a monthly schedule. The SWG core members (Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager) and qualified alternate members are identified to ensure back-up coverage when a primary member is unable to attend. Core Members were educated on the required monthly participation in the SWG meetings. Attendance is tracked and recorded at each meeting by the SWG Minutes Recorder. Quality Management Staff audited the SWG minutes and verified documentation of core members attendance.

Expected Compliance: A target of 90% or greater compliance for the SWG core member's attendance was achieved for six consecutive months from July 2021 to January 2022. There was no meeting in December 2021.

Quality Management staff will continue to audit SWG minutes for attendance of core members for an additional two quarters to ensure sustainability and report compliance to the Quality Safety Value (QSV) committee, quarterly.

VHA requires medical facilities that have surgery programs to have a surgical work group responsible for the "monthly review of surgical deaths, an analysis of efficiency and utilization metrics, …a review of NSO [National Surgery Office] surgical quality reports, and an evaluation of critical surgical events."[64] The OIG reviewed Facility Surgical Workgroup meeting minutes from April 2020 to March 2021 and did not find evidence that the group reviewed surgical deaths or evaluated critical surgical events. Failure to review and analyze surgical data may have

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

[64] VHA Directive 1102.01(1).

resulted in missed opportunities to improve patient safety in the surgical program. The Chief of Surgery stated that it was redundant to review surgical deaths in both the Morbidity and Mortality conference and Facility Surgical Workgroup, and that critical surgical events were reviewed but not annotated in meeting minutes.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Facility Surgical Workgroup reviews surgical deaths and evaluates critical surgical events as required.[65]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Chief of Staff evaluated the reasons for non-compliance and determined there were no additional reasons for non-compliance. The Chief of Staff reviewed the Surgical Work Group (SWG) minutes and found that surgical deaths and critical surgical events were not a part of the monthly SWG standing agenda items. These items were discussed in mortality and morbidity and the committee meetings but not documented in the minutes. Starting in July 2021, the Surgical Work Group added monthly reviews of surgical deaths and critical surgical events to the standing agenda. National Surgery Office (NSO) Quality Reports continue to be a standing agenda item for quarterly reporting. SWG has identified and educated a qualified staff member responsible to report monthly surgical deaths. Quality Management Staff audited the SWG minutes and verified documentation that the monthly surgical death reports were presented and discussed.

Expected Compliance: A target of 90% or greater compliance for monthly documentation of surgical death reviews, documented in the SWG minutes was achieved for six consecutive months from July 2021 to January 2022.

Quality Management staff will continue to audit SWG minutes for monthly reporting of surgical deaths for an additional two quarters to ensure sustainability and report compliance to the Quality Safety Value (QSV) committee, quarterly.

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

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."[66] 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."[67]

VA requires all RNs to hold at least one active, unencumbered license.[68] 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.[69] 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.[70] 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.[71]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 17 RNs hired from July 1, 2020, through May 19, 2021. The OIG determined whether

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

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

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[66] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (This directive was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers,* September 15, 2021. The two documents contain similar language regarding credentialing procedures.)

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

[68] 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."

[69] 38 U.S.C. § 7402.

[70] VHA Directive 2012-030, replaced by VHA Directive 1100.20.

[71] VHA Directive 2012-030, replaced by VHA Directive 1100.20.

Registered Nurse Credentialing Findings and Recommendations

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

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[72] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[73]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[74] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[75]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[76] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[77]

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

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

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

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

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

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

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

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

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
  - Potential pregnancy
  - Kidney assessment (estimated glomerular filtration rate)[78]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[79]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The medical center addressed many of the indicators of expected performance, including availability of staff to receive medication shipments, completion of required testing prior to medication administration, and reporting of adverse events to the FDA. However, the OIG identified deficiencies with the provision of patient or caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, inform patients or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[80] For the seven electronic health records reviewed, the OIG found that healthcare providers did not

- provide any of the patients or caregivers with the *Fact Sheet for Patients and Parents/Caregivers*,
- inform 71 percent of patients or caregivers that remdesivir was not FDA-approved,
- advise 43 percent of patients or caregivers of the option to refuse remdesivir, or
- advise 71 percent of patients or caregivers of the risks, benefits, and alternatives to receiving remdesivir prior to administration.

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

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

[80] VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

This could have resulted in patients or caregivers lacking the information needed to make a fully informed decision to receive the medication. The Chief of Infectious Medicine stated that all Emergency Use Authorization requirements were met, but due to time constraints, counseling sessions were summarized in the electronic health record and not fully documented.

Given the FDA's approval of remdesivir for use in adult patients requiring hospitalization for the treatment of COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.[81]

[81] Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19."

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[82] 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.[83] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[84]

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.[85] 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.[86] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

[85] 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.

[86] 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 50 randomly selected patients who were seen in the emergency department or urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[87]

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."[88] 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.[89]

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

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

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 40 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG found general compliance with requirements for the existence of an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, completion of the VA *Inter-Facility Transfer Form* or facility-defined equivalent, transmission of patient's active medication

[87] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. (This directive was rescinded and replaced by VHA Directive 1094, *Inter-Facility Transfer*, January 20, 2022. The two documents contain similar language regarding the risks of patient transfers.)

[88] VHA Directive 1094. (The updated directive removed the requirement for facilities to have a written policy.)

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

list, and communication between nurses at sending and receiving facilities. However, the OIG noted that staff did not consistently send patients' advance directives to receiving facilities.

VHA requires the Chief of Staff and ADPCS/Chief Nurse Executive to ensure that the transferring physicians or assigned designees "send all pertinent medical records available, including…documentation of the patient's advance directive made prior to transfer, if any" to the receiving facility.[90] The OIG found that for 15 transfers where the patient had an advanced directive, 93 percent of those electronic health records lacked evidence that staff sent a copy to the receiving facility.[91] As a result, there was no assurance that receiving facility staff could determine patients' healthcare preferences at transfer. The Emergency Department acting Nurse Manager and Medical-Surgical Nursing Director reported that staff sent advance directives to receiving facilities but did not document it because the medical center's transfer note template did not require advance directive information. Due to the low number of patients identified for this review element, the OIG made no recommendation.

[90] VHA Directive 1094.

[91] The OIG estimated that 95 percent of the time, the true compliance rate is between 0.01 and 22.23 percent, which is statistically significantly below the 90 percent benchmark.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[92] 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."[93] 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[94]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[95]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[96]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[97]

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

[93] VHA Directive 2012-026.

[94] 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."

[95] 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."

[96] 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."

[97] 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 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.[98] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[99] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The medical center generally met requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with required members' attendance at Disruptive Behavior Committee meetings and staff training.

VHA requires that the Chief of Staff and Nurse Executive (ADPCS/Chief Nurse Executive) establish a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; a patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the Union Safety Committee.[100] The committee or board is responsible for coordinating with clinicians, recommending amendments to the patients' treatment plans that may reduce the patients' risk of violence, collecting and analyzing disruptive patient incidents, identifying system problems, and recommending to the Chief of Staff other actions related to the problem of patient violence.[101]

The OIG reviewed attendance for the Disruptive Behavior Committee from April 2020 through March 2021.[102] Of the 12 meetings held, the OIG found that a patient safety or risk management representative did not attend 9 (75 percent), a representative from the Prevention and Management of Disruptive Behavior Program did not attend 8 (67 percent), administrative support staff and the Patient Advocate did not attend 6 (50 percent), and VA police did not attend 5 (42 percent). This could prevent the committee members from consistently taking a

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

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

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

[101] VHA Directive 2010-053.

[102] At this medical center, the Disruptive Behavior Committee reports to the Chief of Staff.

comprehensive approach when assessing patients' disruptive behavior and establishing a safe environment for clinical care. The Director of Learning, Talent Management Coordinator, and Medical Administration Specialist stated that administrative support staff were reassigned during the pandemic. The Prevention and Management of Disruptive Behavior representative, Deputy Chief of Police, Patient Safety Officer, and Patient Advocate cited conflicting priorities as the reason for the lack of attendance.

Recommendation 4

4. The Chief of Staff and Nurse Executive (ADPCS/Chief Nurse Executive) evaluate and determine any additional reasons for noncompliance and ensure all required members attend Disruptive Behavior Committee meetings.

Medical center concurred.

Target date for completion: August 1, 2022

Medical center response: The Chief of Staff and ADPCS/Chief Nurse Executive evaluated the reasons for non-compliance and determined there were no additional reasons for non-compliance. The Chair and Co-Chair of the DBC [Disruptive Behavior Committee] are responsible for monitoring core members or their designated representatives' attendance at all scheduled DBC meetings and implement corrective actions when core members or alternate representatives do not attend scheduled meetings. The DBC membership roster was revised, core members are in the process of being appointed, and qualified alternate representatives were selected for each core member. DBC Chair will ensure that core members/alternate are invited to all scheduled meetings and will maintain a record of attendance. The first meeting for the revised membership will be on February 16, 2022 where the DBC charter will be reviewed.

Expected Compliance: The Chair of the DBC will monitor attendance data and report to the Quality Safety Value (QSV) committee monthly until 90% attendance is sustained for six consecutive months. Data collection will be from February 2022 to July 2022. The Chief of Staff and Chief Nurse Executive/ADPCS are members of QSV committee.

VHA requires employees to complete prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[103] The OIG found that 57 percent of employees did not complete the required training based on their work area's risk level. This could result in employees' lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Director of Learning, Talent Management System Coordinator stated that staff failed to respond to training reminders and leaders ceased in-person trainings because

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

the small classroom prevented adherence to social distancing guidelines. Additionally, the Prevention and Management of Disruptive Behavior Coordinator reported that all five trainers were detailed to other positions and unable to provide training.

Recommendation 5

5. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[104]

Medical center concurred.

Target date for completion: August 1, 2022

Medical center response: The Medical Center Director evaluated the reasons for non-compliance and determined there were no additional reasons for non-compliance. In January 2022, Quality Management staff reviewed the facility's Prevention and Management of Disruptive Behavior (PMDB) training records and found that 98% of the staff received level 1 training for the past six months, and the level 2 and level 3 training requirement was not in compliance. Level 2 and level 3 in-person training was suspended for the past six months due to COVID-19 social distancing restrictions and the shortage of PMDB trainers due to staff detailed to support the COVID-19 response. The facility will resume the face-to-face PMDB training starting 1/31/22. The Disruptive Behavior Committee (DBC) Chair and the Talent Management System (TMS) Coordinator are responsible for implementing actions to ensure PMDB training is completed as assigned. The number of staff that requires level 2 and level 3 in-person (4-hours) training have been identified and assigned training according to risk level. PMDB trainers will provide at least one training day a week to meet the facility's PMDB Program staff training needs. The Education Department will coordinate with service supervisors to schedule and remind staff to attend PMDB training classes and recruit an additional dedicated PMDB trainer by May 30, 2022 to support PMDB Program training needs.

Expected Compliance: The Chair of the DBC in coordination with the TMS Coordinator will monitor PMDB level 2 and level 3 training compliance and report data to the Quality Safety Value (QSV) committee monthly until 90% training compliance is sustained for six consecutive months. Data collection will be from February 2022 to July 2022. The Medical Center Director is a member of the QSV committee.

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

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed review of eight clinical and administrative areas and provided five recommendations on issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this medical center. However, the OIG's findings illuminate areas of concern and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines five OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Medical Center Director, Chief of Staff, and ADPCS/Chief Nurse Executive. The intent is for these leaders to use the recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

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

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• The Facility Surgical Workgroup reviews surgical deaths and evaluates critical surgical events as required.	• The Peer Review Committee submits a quarterly summary analysis for review by the Medical Executive Committee. • Required members attend Facility Surgical Workgroup meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• None	• None
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• Required members attend Disruptive Behavior Committee meetings. • Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

Appendix B: Medical Center Profile

The table below provides general background information for this high complexity (1b) affiliated medical center reporting to VISN 2.[1]

Table B.1. Profile for James J. Peters VA Medical Center (526)
(October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019	Medical Center Data FY 2020‡
Total medical care budget	$351,388,518	$339,842,922	$359,151,167
Number of:			
• Unique patients	26,157	26,143	25,528
• Outpatient visits	350,594	348,660	325,925
• Unique employees§	1,551	1,528	1,516
Type and number of operating beds:			
• Community living center	80	80	80
• Intermediate	10	10	10
• Medicine	81	81	81
• Mental health	30	30	30
• Rehabilitation medicine	9	9	9
• Spinal cord	82	82	82
• Surgery	33	33	33

[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 "1b" indicates a facility with "medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs." An affiliated healthcare system is associated with a medical residency program.

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019	Medical Center Data FY 2020‡
Average daily census:			
• Community living center	44	48	45
• Medicine	30	29	32
• Mental health	19	15	10
• Rehabilitation medicine	1	0	0
• Spinal cord	30	27	23
• Surgery	12	11	10

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

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

*****October 1, 2017, through September 30, 2018.*

October 1, 2018, through September 30, 2019.

‡*October 1, 2019, through September 30, 2020.*

§*Unique employees involved in direct medical care (cost center 8200).*

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
White Plains, NY	526GA	1,681	754	Gastroenterology Gynecology Neurology	–	Nutrition Pharmacy
Yonkers, NY	526GB	1,122	470	Gastroenterology	–	Nutrition Pharmacy
Sunnyside, NY	526GD	797	1	–	–	Nutrition Pharmacy

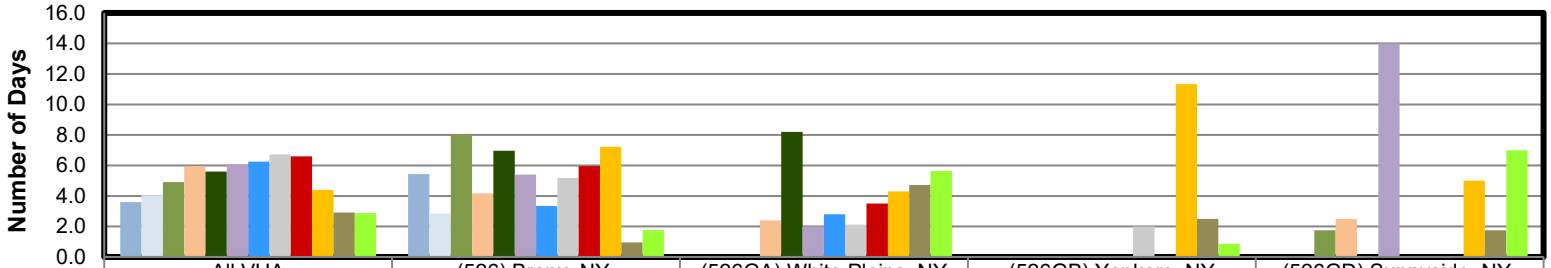
Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

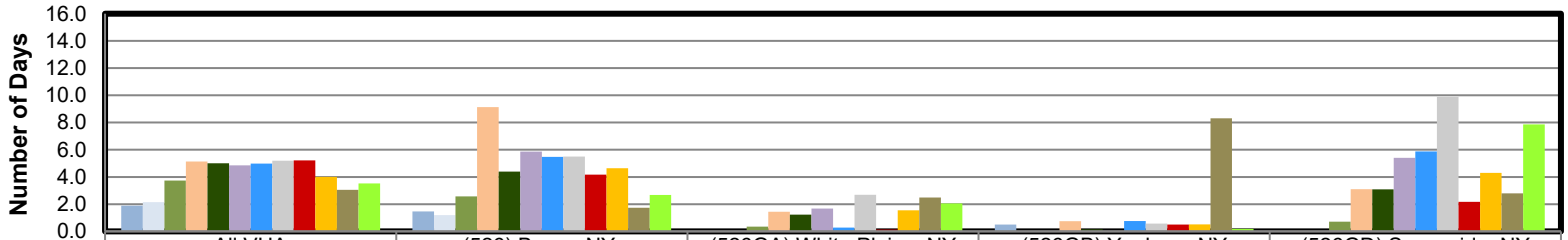


	All VHA	(526) Bronx, NY	(526GA) White Plains, NY	(526GB) Yonkers, NY	(526GD) Sunnyside, NY
APR-FY20	3.6	5.4	n/a	n/a	0.0
MAY-FY20	4.0	2.8	n/a	n/a	0.0
JUN-FY20	4.9	8.0	0.0	0.0	1.8
JUL-FY20	5.9	4.2	2.4	n/a	2.5
AUG-FY20	5.6	7.0	8.2	0.0	0.0
SEP-FY20	6.1	5.4	2.0	n/a	14.0
OCT-FY21	6.3	3.3	2.8	0.0	n/a
NOV-FY21	6.7	5.2	2.1	2.0	n/a
DEC-FY21	6.6	6.0	3.5	0.0	n/a
JAN-FY21	4.4	7.2	4.3	11.3	5.0
FEB-FY21	2.9	1.0	4.7	2.5	1.8
MAR-FY21	2.9	1.8	5.6	0.9	7.0

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vaww.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 possibly create date. The absence of reported data is indicated by "n/a."



	All VHA	(526) Bronx, NY	(526GA) White Plains, NY	(526GB) Yonkers, NY	(526GD) Sunnyside, NY
APR-FY20	1.9	1.5	0.0	0.5	0.0
MAY-FY20	2.1	1.2	0.0	n/a	0.0
JUN-FY20	3.7	2.6	0.4	0.0	0.7
JUL-FY20	5.1	9.1	1.4	0.8	3.1
AUG-FY20	5.0	4.4	1.2	0.1	3.1
SEP-FY20	4.9	5.9	1.7	0.0	5.4
OCT-FY21	5.0	5.5	0.3	0.8	5.9
NOV-FY21	5.2	5.5	2.7	0.6	9.9
DEC-FY21	5.2	4.2	0.1	0.5	2.2
JAN-FY21	4.0	4.6	1.5	0.5	4.3
FEB-FY21	3.1	1.7	2.5	8.3	2.8
MAR-FY21	3.5	2.7	2.1	0.2	7.9

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vaww.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." The absence of reported data is indicated by "n/a."

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use 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	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	Care coordination (PCMH)	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	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: February 2, 2022

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

Subj: Comprehensive Healthcare Inspection of the James J. Peters VA Medical Center in Bronx, New York

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

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 James J. Peters VA Medical Center in Bronx, 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: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 2, 2022

From: Director, James J. Peters VA Medical Center (526/00)

Subj: Comprehensive Healthcare Inspection of the James J. Peters VA Medical Center in Bronx, New York

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

I have reviewed the VA OIGs report, as well as the James J. Peters VAMC response and concur with the findings, recommendations, and action plans submitted therein.

(Original signed by:)

Rosemary Cancel-Santiago
Interim Medical Center Director

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