DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Western New York Healthcare System in Buffalo

CHIP REPORT | REPORT #21-00290-116 | APRIL 6, 2022

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Figure 1. *VA Western New York Healthcare System in Buffalo. Source: https://www.va.gov/western-new-york-health-care/ (accessed June 16, 2021).*

Abbreviations

ADPNS	Associate Director for Patient/Nursing 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
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Western New York Healthcare System, which includes the Buffalo and Batavia VA Medical Centers and multiple 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 VA Western New York Healthcare System 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 healthcare system's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings may help this healthcare system and other Veterans Health Administration (VHA) facilities

[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)."

identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

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

Leadership and Organizational Risks

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

When the team conducted this inspection, the healthcare system's leaders had worked together for about five months, although several had served in their positions for multiple years. The Associate Director, who was assigned in April 2016, was the most tenured leader. The Chief of Staff, assigned in January 2021, was the newest member of the leadership team. The Assistant Director, Director, and Associate Director for Patient/Nursing Services were assigned February 2017, and August and September 2018, respectively.

The healthcare system's fiscal year 2020 annual medical care budget increased by 18 percent when compared to the previous year's budget. Additionally, leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

The OIG reviewed survey results and concluded that the Chief of Staff, Associate Director for Patient/Nursing Services, and Assistant Director had opportunities to improve employee satisfaction. Additionally, the Director, Associate Director for Patient/Nursing Services, and Assistant Director had opportunities to reduce staff feelings of moral distress at work.[2] While

[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 survey results are not reflective of employee satisfaction with the current Chief of Staff, who assumed the role after the survey was administered.

selected patient experience survey scores were generally similar to or higher than the VHA averages, gender-specific results highlighted opportunities for leaders to improve female patients' ratings related to the likelihood of recommending the hospital to others, and patient-centered medical home provider quality. Patients generally appeared satisfied with the care provided.

The inspection team also reviewed accreditation agency findings and disclosures of adverse patient events and did not identify substantial organizational risk factors. However, the OIG identified concerns related to sentinel events and institutional disclosures.[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 generally knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures.[6] In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The healthcare system complied with requirements for a committee responsible for quality, safety, and value oversight functions and the Systems Redesign Improvement Program.

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[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.

However, the OIG identified weaknesses in protected peer review and Surgical Work Group processes.[7]

Medication Management

The OIG found the healthcare system addressed many of the indicators of expected performance, including the availability of staff to receive remdesivir shipments, proper naming of medication orders, and completion of required tests prior to remdesivir administration. However, the OIG identified deficiencies with the provision of patient or caregiver education.

Care Coordination

Generally, the healthcare system met expectations for the completion of required elements of the VA *Inter-Facility Transfer Form*, transmission of active medication lists and advance directives to the receiving facility, and communication between nurses at sending and receiving facilities.[8] However, the OIG identified a deficiency with monitoring and evaluation of inter-facility transfers.

High-Risk Processes

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

Conclusion

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

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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. 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.

VA Comments

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

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Assistant Inspector General
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Contents

Purpose and Scope

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

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

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

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

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

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

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

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

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

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

5. Medication management (targeting remdesivir use)
6. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
7. Care coordination (spotlighting inter-facility transfers)
8. High-risk processes (examining the management of disruptive and violent behavior)

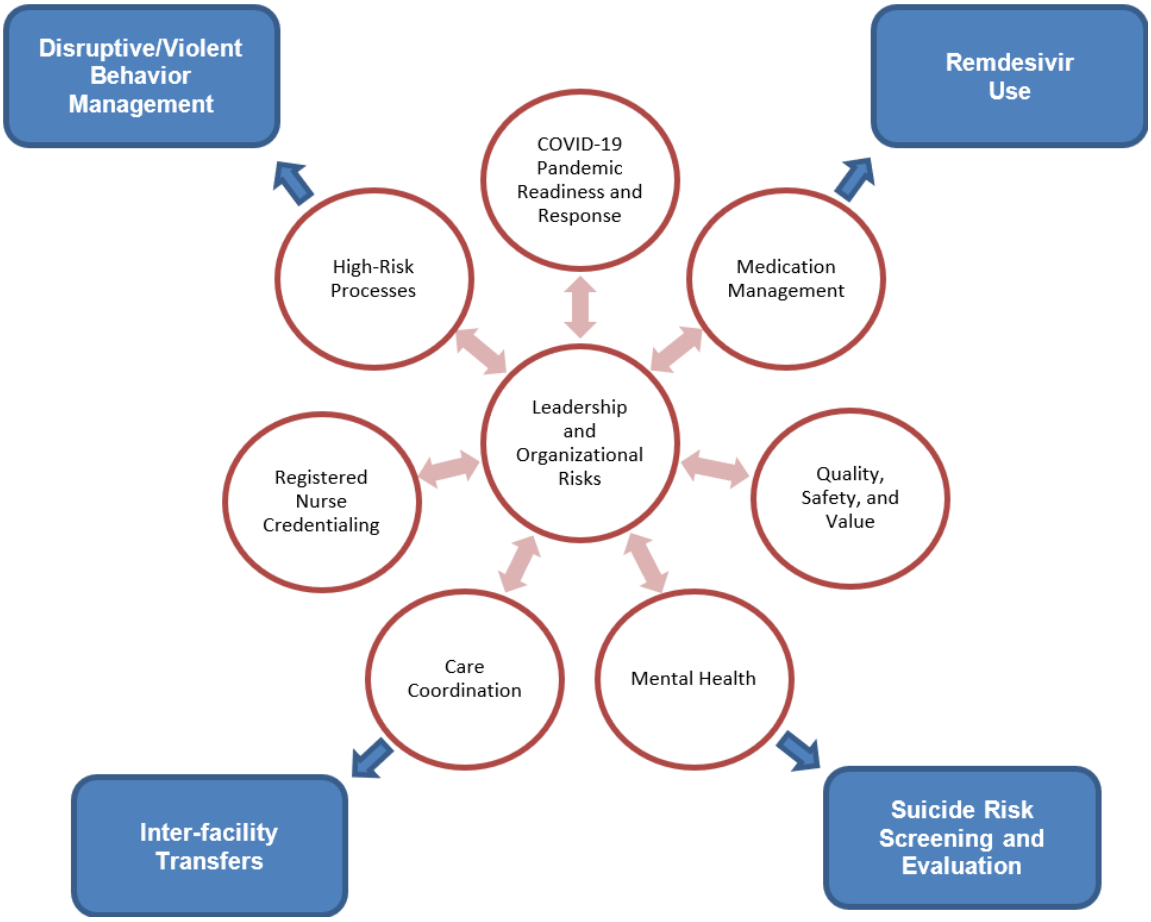


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

The VA Western New York Healthcare System includes the Buffalo and Batavia VA Medical Centers and multiple outpatient clinics in New York. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from March 22, 2019, through June 25, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

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

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that healthcare 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 healthcare system's risks, the OIG considered several indicators:

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

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient/Nursing Services (ADPNS), Associate Director, and Assistant Director. The Chief of Staff and ADPNS 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.

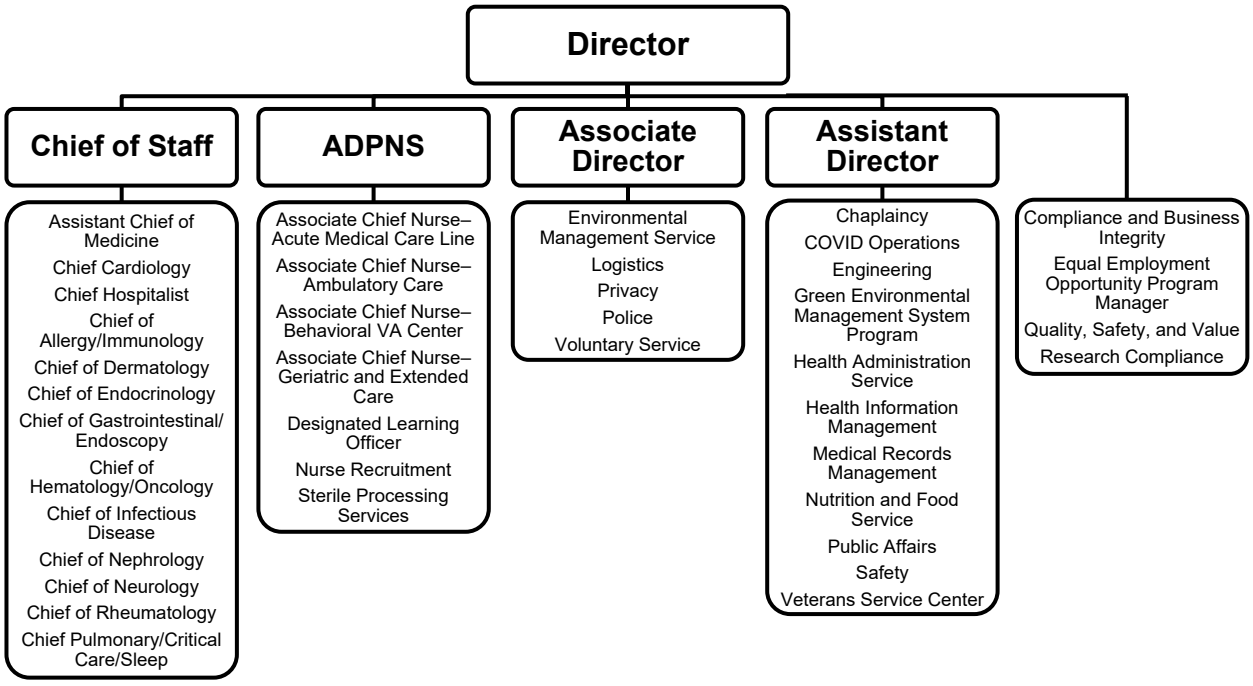


Figure 3. *Healthcare system organizational chart.*

Source: VA Western New York Healthcare System (received June 22, 2021).

At the time of the OIG inspection, the executive team had worked together for about five months. The Associate Director, assigned in April 2016, was the most tenured leader. The Chief of Staff, assigned in January 2021, was the newest member of the leadership team. Other executive leaders had been in their positions for more than one year (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	August 5, 2018
Chief of Staff	January 17, 2021
Associate Director for Patient/Nursing Services	September 4, 2018
Associate Director	April 15, 2016
Assistant Director	February 6, 2017

Source: VA Western New York Healthcare System Assistant Human Resources Officer (received June 22, 2021).

The Director served as the chairperson of the Local Leadership Committee, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Local Leadership Committee oversaw various working groups such as the Executive Committees of Medical Staff, Health Systems, and Nursing Staff. The leaders monitored patient safety and care through the QSV Committee, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

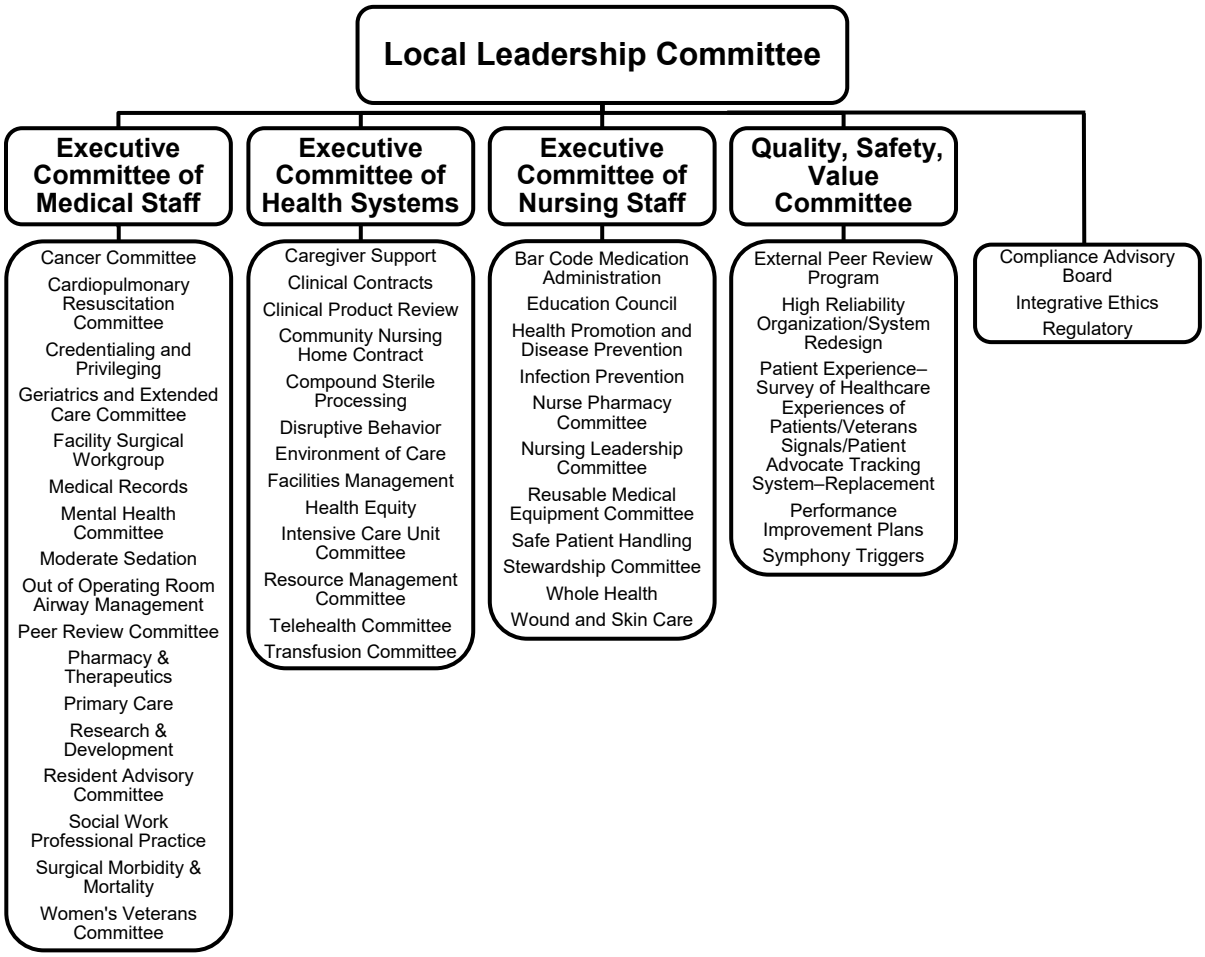


Figure 4. *Healthcare system committee reporting structure.*

Source: VA Western New York Healthcare System (received June 22, 2021).

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPNS, and Associate Director regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $1,554,722,307 increased by 18 percent when compared to the previous year's budget of $1,319,985,152.[11] When asked about the effect of this change on the healthcare system's operations, the Director indicated that most of the increase helped address COVID-19 pandemic needs. Specifically, the Director

[11] VHA Support Service Center.

described using the funds to construct negative pressure rooms and pay overtime to employees who covered COVID-19 units.

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] Most of the executive leaders confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection. The Chief of Staff stated that some of the shortages remain the same but added that gastroenterology, neurology, and cardiac services should also be on the list. Additionally, the Chief of Staff reported that leaders addressed the psychiatry shortage by hiring advanced practice RNs and physician assistants and partnering with local colleges to recruit medical support assistants. The ADPNS described supplementing the nursing staff with float, intermittent, and part-time staff.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Psychiatry	1. Safety and Occupational Health Management
2. Nurse	2. Medical Support Assistant
3. Chaplain	3. General Engineering
4. Dietitian and Nutritionist	4. Cook
5. RN Staff–Inpatient Mental Health	5. Purchasing

Source: VA OIG.

[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*.

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 healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[18] Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. The OIG found the healthcare system averages for the selected survey leadership questions were lower than the VHA averages.[19] The OIG noted the same trend for most of the Chief of Staff, ADPNS, and Assistant Director's scores. However, the Director and Associate Director's scores were consistently higher than those for VHA and the healthcare system.[20]

[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."

[18] Ratings are based on responses by employees reported to or were aligned under the Director, Chief of Staff, ADPNS, Associate Director, and Assistant Director.

[19] 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.

[20] 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.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPNS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	70.8	80.0	57.5	65.7	87.0	63.1
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.3	4.4	3.0	3.3	4.3	3.3
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.4	4.4	3.2	3.6	4.5	3.4
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.5	4.5	3.1	3.4	4.7	3.4

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] The healthcare system averages for the selected survey questions were similar to the VHA averages. Scores for the executive leaders were generally similar to or better

[21] Ratings are based on responses by employees who reported to or were aligned under the Director, Chief of Staff, ADPNS, Associate Director, and Assistant Director.

than those for VHA and the healthcare system. However, opportunities appeared to exist for the Assistant Director to improve employees' comfort with disclosing suspected violations without fear of reprisal, and for the Director, ADPNS, and Assistant Director to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing). The Director and ADPNS reported that they addressed employee feelings of moral distress by conducting town halls, being accessible and visible, and increasing communication.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPNS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	4.6	3.7	3.7	4.8	3.3
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.6	3.9	3.6	4.3	4.2	3.5

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPNS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.4	1.8	1.2	1.6	0.8	2.5

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."[22] To this end, leaders initiated the "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[23] The Director also reported implementing strategies from VA's "Stand Up to Stop Harassment Now!" campaign and described holding an all-employee town hall where the leadership team, supervisors, and employees signed the campaign poster.[24] The Director stated that the signed poster was displayed in the lobby of the Buffalo VA Medical Center.

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

[22] "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/. (This is an internal website not publicly accessible.) Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPNS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.7	3.6	3.9	3.6	4.5	3.5
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.0	4.3	3.9	4.0	4.8	3.6
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	4.1	3.6	3.6	4.3	3.3

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

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides survey results for VHA and the healthcare system.[25] For this system, overall patient satisfaction survey results generally reflected higher care ratings than the VHA averages. Patients appeared satisfied with the care provided.

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

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

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	73.7
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	85.4
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	85.2

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

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). The results for male respondents were generally similar to or more favorable than the corresponding VHA averages. Although female inpatients largely rated their experiences more positively than female patients nationally, results indicated that they were less likely to recommend the hospital to family and friends and had lower ratings for patient-centered medical home providers. Leaders appeared to be actively engaged with male and female patients (for example, the Director reported listening to patients and addressing

[26] "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.

concerns as they arose, and the ADPNS discussed increasing the number of staff to support patient care).

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	74.6	59.0
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	86.6	92.4
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	89.8	83.8

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

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

†The healthcare system averages are based on 449 or 451 male and 21 or 22 female respondents, depending on the question.*

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	62.2	46.4
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	64.5	56.1
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	74.1	58.5

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

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

†*The healthcare system averages are based on 543–1,808 male and 26–72 female respondents, depending on the question.*

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	58.4	76.2
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	61.8	80.2
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	75.1	88.6

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

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

†*The healthcare system averages are based on 408–1,319 male and 17–62 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.[27] Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint

[27] "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."

Commission (TJC).[28] At the time of the OIG review, system leaders had closed all recommendations for improvement issued since the previous CHIP site visit conducted in March 2019. The OIG team also noted the results from the Long Term Care Institute's inspection of the system's CLCs.[29]

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 of the VA Western New York Healthcare System, Buffalo, New York*, Report No. 18-04666-55, January 7, 2020)	March 2019	18	0
TJC Laboratory	April 2021	6	0

Source: OIG and TJC (inspection/survey results received from the Chief, QSV on June 22, 2021).

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

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

[28] 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."

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

Table 11 lists the reported patient safety events from March 22, 2019 (the prior OIG CHIP site visit), through June 22, 2021.[30]

Table 11. Summary of Selected Organizational Risk Factors (March 22, 2019, through June 22, 2021)

Factor	Number of Occurrences
Sentinel Events	0
Institutional Disclosures	4
Large-Scale Disclosures	0

Source: VA Western New York Healthcare System's Chief, QSV and Risk Manager (received June 22-25, 2021).

The Director reported being informed of serious adverse patient events during "morning report" meetings with leaders; through direct contact from the Chief, QSV or Patient Safety Manager; and by serving as the chair of the QSV Committee. The Director also described collaborating with staff, assessing all events, and adhering to VHA policy to determine when an institutional disclosure was warranted. The OIG reviewed the four institutional disclosures and determined that all four met the definition of a sentinel event. More details about this are discussed in the findings and recommendations section.

Veterans Health Administration Performance Data for the Healthcare System

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within

[30] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The VA Western New York Healthcare System 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."

VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[31] 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.[32]

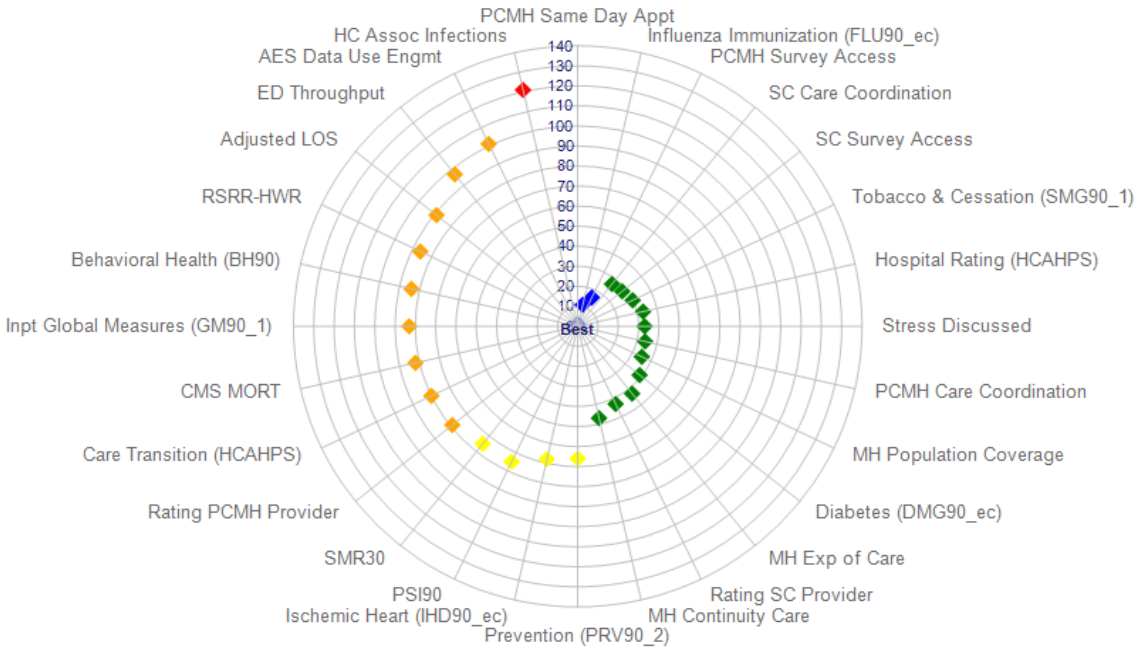
The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL and CLC SAIL measures. In individual interviews, the executive leaders were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance.

Figures 5 illustrates the quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the Buffalo VA 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, patient-centered medical home (PCMH) same day appointment (appt), PCMH survey access, specialty care (SC) survey access, and hospital rating (HCAHPS)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, rating (of) PCMH provider, adjusted length of stay (LOS), and health care (HC) associated (assoc) infections).[33]

[31] "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.)

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

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



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

Figure 5. *Buffalo VA 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.

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."[34] 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."[35]

Figures 6 and 7 illustrate the system's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. Figure 6 displays the Buffalo VA Medical Center's CLC metrics with high performance (blue and green data points) in the first and second quintiles

[34] 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.

[35] 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."

(for example, new or worse pressure ulcer (PU)–short-stay (SS), discharged to community (SS), and improvement in function (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, rehospitalized after nursing home (NH) admission (SS), outpatient emergency department (ED) visit (SS), and newly received antipsychotic (antipsych) medication (meds) (SS)).[36]

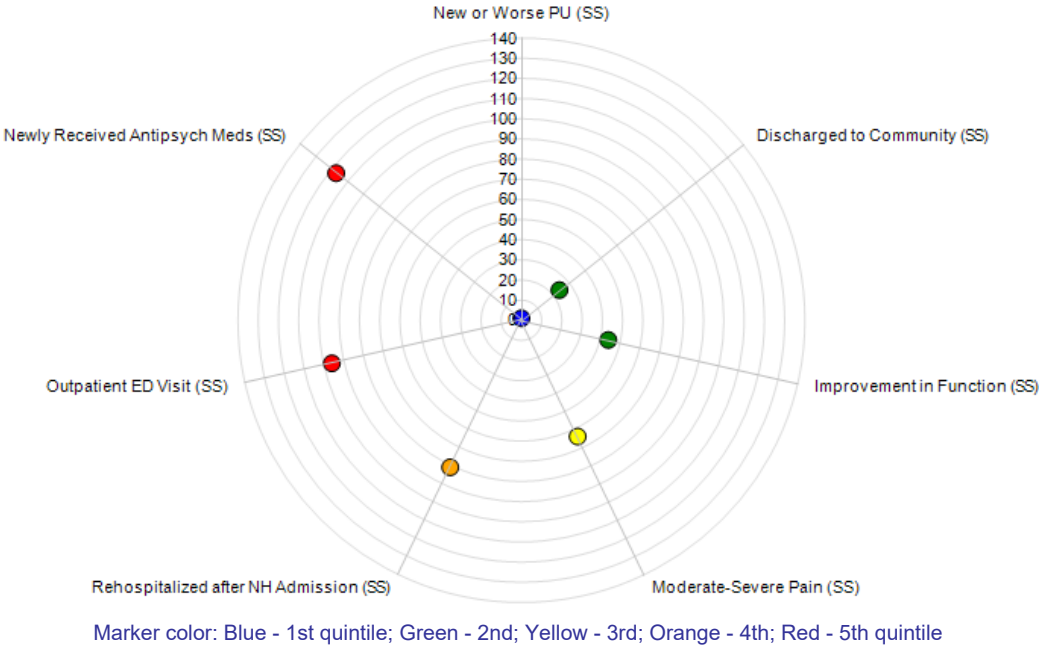


Figure 6. *Buffalo VA Medical Center CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).*

SS = Short-Stay Measure.

Source: VHA Support Service Center.

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

Figure 7 uses blue data points to indicate high performance metrics for the Batavia VA Medical Center's CLC (for example, falls with major injury–long-stay (LS) and high risk PU (LS)). Metrics that need improvement are denoted in red (for example, urinary tract infection (UTI) (LS), help with activities of daily living (ADL) (LS), physical restraints (LS), and ability to move independently worsened (LS)).

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

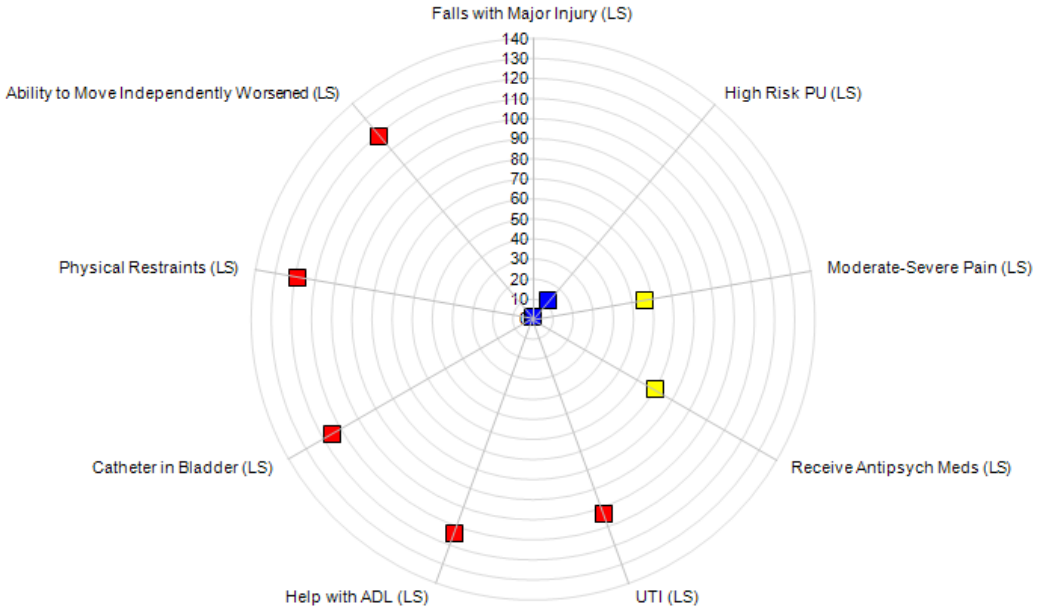


Figure 7. *Batavia VA Medical Center CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).*

LS = Long-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 virtual visit, the system's executive leadership team had worked together for about five months. The Associate Director, assigned in April 2016, was the most tenured leader. The Chief of Staff, assigned in January 2021, was the newest member of the leadership team. Other executive leaders had been in their positions for more than one year.

The Director served as the chairperson of the Local Leadership Committee, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. During an interview with the OIG about the annual budget, the Director indicated that most of the 18 percent increase helped address COVID-19 pandemic needs. Specifically, the Director described using the funds to construct negative pressure rooms and pay overtime to employees who covered COVID-19 units. Additionally, the leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Specific survey data revealed that leaders had opportunities to improve employee satisfaction. Selected patient experience scores implied general satisfaction. However, gender-specific survey results highlighted opportunities for leaders to improve female patients' likelihood of

recommending the hospital, and patient-centered medical home provider experiences. The executive leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences.

The leadership team, while generally knowledgeable within their scope of responsibility about system and CLC SAIL measures, had opportunities to improve quality of care and efficiency metrics and should take actions to improve performance.

The OIG's review of the system's accreditation findings and disclosures did not identify any organizational risk factors. However, the OIG determined four adverse events that resulted in institutional disclosures were not identified as sentinel events.

TJC defines a sentinel event as a category of patient safety events "that reaches the patient and results in any of the following: death, permanent harm, severe temporary harm and intervention required to sustain life."[37] Furthermore, TJC expects accredited facilities to identify, investigate, and disclose sentinel events to the patient or family.[38] In support of TJC, VHA established the Patient Safety Program to prevent patient harm. To accomplish this, all facility staff are responsible for reporting "any unsafe condition even if an adverse event has not occurred." In addition, leaders are accountable for identifying sentinel events, conducting a review to determine the root cause, implementing actions to prevent future occurrences, and maintaining an accurate record of all events.[39]

The OIG requested information on sentinel events and institutional disclosures from March 22, 2019, through June 22, 2021. The Risk Manager reported that leaders conducted four institutional disclosures. However, the OIG found that staff did not properly identify any of the disclosed occurrences as sentinel events. Failure to identify sentinel events may lead to missed opportunities for staff to recognize safety trends and report patient harm, or cause delays in mitigating risks of future events. The Chief of Staff stated that the cases should have been identified as sentinel events but could not explain why the cases were not reported. Similarly, the Risk Manager could not explain why the four adverse events were not identified as sentinel events but provided evidence that staff conducted a root cause analysis for three of the events, and one of the three was also peer-reviewed.

[37] The Joint Commission, *Sentinel Events*, *Comprehensive Accreditation Manual for Hospitals*, January 2021, accessed March 2, 2021, https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-policy-and-procedures/.

[38] The Joint Commission, *Sentinel Events*, *Comprehensive Accreditation Manual for Hospitals*.

[39] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

Recommendation 1

1. The Director evaluates and determines the reasons for noncompliance and makes certain that leaders accurately identify and report adverse events as sentinel events when criteria are met.

Healthcare system concurred.

Target date for completion: August 31, 2022

Healthcare system response: The reasons for non-compliance were considered when developing the action plan. All reports of adverse events will be reviewed by the Risk Managers and Patient Safety Managers in collaboration with the Chief, Quality, Safety & Value. Adverse events identified as meeting the criteria of sentinel events as described in VHA Handbook 1050.1 and the Joint Commission Standards will be labeled as such. Patient Safety will record incidents, identify safety trends, and efforts in mitigating risks for future events and report quarterly to the Quality Safety, Value Committee chaired by the Director. This process will go into effect starting February 2022 and compliance will be monitored for six consecutive months or two consecutive quarters.

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 healthcare system and its leaders' subsequent responses. The OIG analyzed performance in the following domains:

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

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

[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 "provision of hospital care and medical services during certain disasters and emergencies…During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[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.

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[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 healthcare system's committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

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

The OIG reviewers also assessed the healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[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 healthcare system'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 healthcare system's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[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; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select

[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.)

specialty programs."[55] The healthcare system's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (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 healthcare system 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 the Peer Review Committee to complete a final review of peer review cases and recommend "non-punitive, non-disciplinary actions to improve the quality of health care delivered."[58] The OIG reviewed six Level 3 peer reviews that were completed from March 16, 2020, through April 22, 2021, and did not find evidence that the Peer Review Committee recommended improvement actions. Lack of recommendations by the Peer Review Committee could hinder learning opportunities and related practice improvements for involved healthcare providers. The Chief of Staff and Risk Manager stated that committee members discussed recommendations during the meetings, and supervisors informally communicated the committee's recommendations to their assigned providers. Also, the Chief of Staff reported being aware of the requirement and believing that informal communication met the requirement.

[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.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that the Peer Review Committee recommends improvement actions for Level 3 peer reviews.

Healthcare system concurred.

Target date for completion: May 31, 2022

Healthcare system response: The reasons for non-compliance were considered when developing the action plan. Upon identifying a Level 3 case, the Peer Review Committee, chaired by the Chief of Staff, will send an Action Item Notification to the appropriate Service Chief for documentation of the action required. Upon review and completion of the action, the form is returned and is included in the Peer Review Committee meetings minutes each month. This process went into effect December 2021 and will be monitored until 90% compliance is met for six consecutive months. The numerator is the number of completed Action Item Notifications returned to the committee. The denominator is the number of level 3 peer reviews identified.

VHA requires medical facility directors to ensure that facilities with surgery programs have a surgical work group that meets monthly; this work group must be chaired by the Chief of Surgery and include the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[59] The OIG reviewed 12 sets of Surgical Work Group minutes for meetings held from July 13, 2020, through June 7, 2021, and found that the Chief of Staff and Operating Room Nurse Manager did not attend four and two meetings, respectively. The lack of executive and surgical leaders' involvement may have resulted in the review and analysis of surgery program data without the perspectives of key staff. The Chief of Staff attributed the noncompliance to the inability of rotating chiefs of staff to cover all responsibilities, scheduling conflicts, and lack of meeting invitations and assigned alternates for core members.

Recommendation 3

3. The Director evaluates and determines any additional reasons for noncompliance and makes certain that required members attend Surgical Work Group meetings.

[59] VHA Directive 1102.01(1).

Healthcare system concurred.

Target date for completion: June 30, 2022

Healthcare system response: The reasons for non-compliance were considered when developing the action plan. Meeting invitations have been sent to all required core members to ensure compliance. The Chief of Staff and the Operating Room Nurse Manager have been advised that their attendance at the Surgical Work Group (a subcommittee of the Executive Committee of the Medical Staff) is mandatory, and alternates have been identified to ensure representation at each meeting. Meeting attendance is reviewed by the Chief of Surgery to ensure the required members or alternates are present. This process was instituted in January 2022 and attendance of required members will be monitored until 100% compliance is met for six consecutive months.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[60] 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."[61]

VA requires all RNs to hold at least one active, unencumbered license.[62] 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.[63] 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.[64] 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.[65]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 39 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 credentialing files for 30 of the 39 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

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

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

[62] 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."

[63] 38 U.S.C. § 7402.

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

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

Registered Nurse Credentialing Findings and Recommendations

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

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[66] 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.[67]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[68] 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.[69]

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."[70] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[71]

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 six 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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[66] 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.

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

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

[69] 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.*

[70] 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.

[71] 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)[72]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[73]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the healthcare system addressed many of the indicators of expected performance, including the availability of staff to receive remdesivir shipments, proper naming of medication orders, and completion of required tests prior to remdesivir administration. However, the OIG identified deficiencies with the provision of patient or caregiver education.

Under the Emergency Use Authorization, the 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.[74] For the six patients who received remdesivir, the OIG determined that healthcare providers did not

- provide any patients or caregivers with the *Fact Sheet for Patients and Parents/Caregivers*,
- inform any patients or caregivers that remdesivir was not an FDA-approved medication,
- provide any patients or caregivers the option to refuse the medication,
- advise five patients or caregivers of the risks and benefits of remdesivir, or

[72] "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."

[73] "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.

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

- advise any patients or caregivers of the alternatives to receiving remdesivir prior to administration.

This could have resulted in the patient or caregiver lacking information needed to make a fully informed decision to receive the medication. The acting Chief of Pharmacy stated that providers were made aware of the requirement for patient or caregiver education but believed that pharmacists' documentation in the electronic health record was sufficient. The OIG did not find evidence of any related patient or caregiver education documented in the records.

Given the FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.[75]

[75] 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.[76] 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.[77] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[78]

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.[79] 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.[80] The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

[79] 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.

[80] 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 healthcare system generally complied with the above requirements. 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.[81]

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."[82] 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.[83]

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

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

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 35 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with requirements for the completion of the required VA *Inter-Facility Transfer Form*, transmission of active medication lists and advance directives to the receiving facility, and communication between nurses at sending and receiving facilities. However, the OIG identified a deficiency with monitoring and evaluation of inter-facility transfers.

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

[82] VHA Directive 1094.

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

VHA requires the Chief of Staff and ADPNS to be responsible for ensuring that "[a]ll transfers are monitored and evaluated as part of VHA's Quality Management Program."[84] The OIG did not find evidence that staff monitored and evaluated patient transfers. Failure to monitor patient transfer data could prevent the identification of system-level deficiencies that may place patients at risk. The Chief, QSV and Associate Chief of Nursing-Inpatient Services reported believing that patient data collected by Care-in-the-Community staff met the VHA requirement for inter-facility transfer monitoring and evaluation. However, the OIG reviewed the data and found that Care-in-the-Community staff collected data to address reimbursement for transfers to non-VA facilities but not to monitor and evaluate all transfers.

Recommendation 4

4. The Chief of Staff and Associate Director for Patient/Nursing Services evaluate and determine any additional reasons for noncompliance and make certain that staff monitor and evaluate all transfers as part of VHA's Quality Management Program.

Healthcare system concurred.

Target date for completion: July 31, 2022

Healthcare system response: The reasons for non-compliance were considered when developing the action plan. The Chief of Staff in collaboration with the Associate Director of Patient/Nursing Services (ADPNS) will ensure all transfers are monitored and evaluated as part of the Quality Management Program. The Inter-Facility Transfers Coordinator will complete the required monitors monthly and report any issues to the Service Chief of that area for improvement. Quarterly reports of chart audits will be reviewed at the Quality, Safety, Value Committee and submitted to the VISN Quality Safety Value Committee. Monitoring of 100% transfer records has been completed in FY 2022 quarter 1 and will continue until 90% compliance is met for six consecutive months or two consecutive quarters.

[84] VHA Directive 1094.

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."[85] 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."[86] 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[87]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[88]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[89]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[90]

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

[86] VHA Directive 2012-026.

[87] 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."

[88] 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."

[89] 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."

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[91] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[92] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG determined that the healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG found deficiencies in Disruptive Behavior Committee meeting attendance and staff training.

VHA requires that the Chief of Staff and ADPNS 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.[93] 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.[94]

The OIG reviewed Disruptive Behavior Committee meeting minutes from August 2020 through June 2021 and found that both the Prevention and Management of Disruptive Behavior Program representative and VA Police did not attend two of nine meetings (22 percent), while the patient safety or risk management representative and patient advocate did not attend five of 9 meetings (56 percent).[95] The OIG also found that administrative support staff did not attend any of the 9 meetings. This could result in the committee taking a less comprehensive approach when

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

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

[93] VHA Directive 2010-053.

[94] VHA Directive 2010-053.

[95] The Disruptive Behavior Committee did not meet in July 2020, September 2020, or January 2021; therefore, the committee held 9 meetings during the review period.

assessing patients' disruptive behavior and carrying out other responsibilities. The Workplace Violence Prevention Program Coordinator reported not understanding the requirement for membership and a lack of commitment from supervisors to require attendance by core members as reasons for noncompliance.

Recommendation 5

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

Healthcare system concurred.

Target date for completion: August 31, 2022

Healthcare system response: The reasons for non-compliance were considered when developing the action plan. The Chair of the Disruptive Behavior Committee (DBC) is responsible for monitoring attendance at all meetings to ensure the required members or their designees are present. Meeting minutes will include a completed roster capturing the names and title of the committee members and indicate if they or a designee were in attendance. The DBC reports to the Executive Committee of Health System, chaired by the Associate Director. The new documentation will go into effect February 2022 and will be monitored until 90% compliance is met for six consecutive months. The numerator is the number of committee meetings attended by required members. The denominator is the number of committee meetings held.

VHA also requires staff to complete prevention and management of disruptive behavior training based on the risk level assigned to their work area.[96] The OIG found that 17 of 30 selected staff (57 percent) had not completed the required trainings. Of the 17 staff who had not completed training, 5 had also not been assigned to a specific work area. This could result in a lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Workplace Violence Prevention Program Coordinator reported that leaders discontinued in-person trainings to prevent staff exposure to COVID-19.

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

Recommendation 6

6. The Director evaluates and determines any additional reasons for noncompliance and ensures that staff complete the required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[97]

Healthcare system concurred.

Target date for completion: July 1, 2022

Healthcare system response: The reasons for non-compliance were considered when developing the action plan. The VISN 2 Network Mental Health Lead working with the VISN 2 Network Designated Learning Officer (DLO) provide monthly Prevention and Management of Disruptive Behaviors (PMDB) training reports to monitor compliance with required workplace violence prevention program training. These reports are emailed via the VISN 2 Action Tracker to our facility Medical Center Action Item Teams to ensure Medical Center Leadership awareness of compliance and action plan progress. Our facility Points of Contact include the Workplace Violence Prevention Program Coordinator and PMDB Coordinator who are responsible for ensuring training compliance at 90%. The Associate Director, Chief of Staff, and ADPNS are responsible for ensuring all facility staff complete the trainings. Our facility will respond with updated monthly action plans detailing plans to come into compliance. This new reconciliation process has gone into effect January 2022 and will be monitored for six consecutive months.

VHA requires the chair and members of the Employee Threat Assessment Team to complete specific workplace violence prevention program training.[98] The OIG found that five of eight team members (63 percent) did not complete the required training. This could result in ineffective de-escalation of employees' disruptive behaviors in times of crisis. The Workplace Violence Prevention Program Coordinator explained that two employees were newly hired and still in the process of training and the remaining three had not completed it because of a communication gap as to who would assign the training.

Recommendation 7

7. The Director evaluates and determines any additional reasons for noncompliance and makes certain that Employee Threat Assessment Team members complete the required training.

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

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

Healthcare system concurred.

Target date for completion: July 1, 2022

Healthcare system response: The reasons for non-compliance were considered when developing the action plan. The Medical Center Director (MCD) will ensure compliance with the VISN action plan to achieve 90% compliance. The VISN 2 Network Mental Health Lead working with the VISN 2 Network DLO will publish monthly Employee Threat Assessment Team (ETAT) training reports to monitor compliance with required training. The training reports will be communicated monthly via the VISN 2 Action Tracker to the medical center leadership to ensure awareness of compliance and action plan progress. The numerator is the number of ETAT members trained. The denominator is the number of ETAT members. The ETAT Chairperson will report with updated monthly actions plans to the MCD if the 90% threshold is not met for six consecutive months. This process was instituted in January 2022.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

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

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• The Peer Review Committee recommends improvement actions for Level 3 peer reviews.	• Required members attend Surgical Work Group 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	• Staff monitor and evaluate all transfers as part of VHA's Quality Management Program.
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• All required representatives attend Disruptive Behavior Committee meetings. • Staff complete required prevention and management of disruptive behavior training based on the risk level assigned to their work areas. • Employee Threat Assessment Team members complete the required training.

Appendix B: Healthcare System Profile

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

Table B.1. Profile for VA Western New York Healthcare System (528) (October 1, 2017, through September 30, 2020)

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
Total medical care budget	$1,323,673,098	$1,319,985,152	$1,554,722,307
Number of: • Unique patients	61,687	62,977	62,077
• Outpatient visits	579,079	581,503	512,653
• Unique employees§	6,159	6,223	6,305
Type and number of operating beds: • Community living center	120	120	120
• Domiciliary	52	52	52
• Medicine	65	65	65
• Mental health	15	15	15
• Surgery	24	24	24
Average daily census: • Community living center	66	106	78
• Domiciliary	37	43	18
• Medicine	48	53	51
• Mental health	12	14	8

[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	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
• Surgery	12	13	10

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

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

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

October 1, 2018, through September 30, 2019.

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

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Jamestown, NY	528GB	2,907	1,273	Anesthesia Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Neurology Otolaryngology Vascular	–	Nutrition Pharmacy Prosthetics Weight management

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Dunkirk, NY	528GC	3,403	592	Dermatology Endocrinology Gastroenterology Neurology Otolaryngology	–	Nutrition Pharmacy Prosthetics Weight management
Niagara Falls, NY	528GD	2,410	824	Dermatology Endocrinology Gastroenterology	–	Nutrition Pharmacy Weight management
Lockport, NY	528GK	2,265	365	Cardiology Dermatology	–	Nutrition Pharmacy Weight management
West Seneca, NY	528GQ	4,170	1,038	Cardiology Dermatology Endocrinology Neurology	–	Nutrition Pharmacy Prosthetics

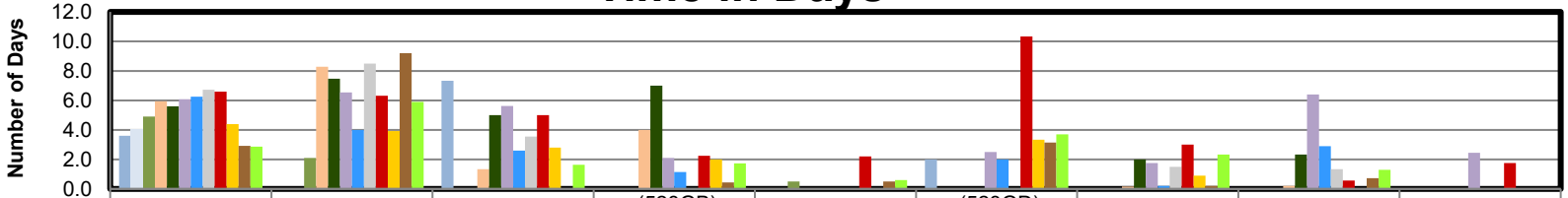
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Olean, NY	528GR	2,421	1,187	Anesthesia Cardiology Dermatology EKG Endocrinology Gastroenterology Hematology/ Oncology Neurology Otolaryngology	EKG	Nutrition Pharmacy Prosthetics Weight management
Buffalo, NY	528QB	346	–	–	–	Pharmacy

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (528QA) Buffalo Main Street, NY, as no data were reported.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days



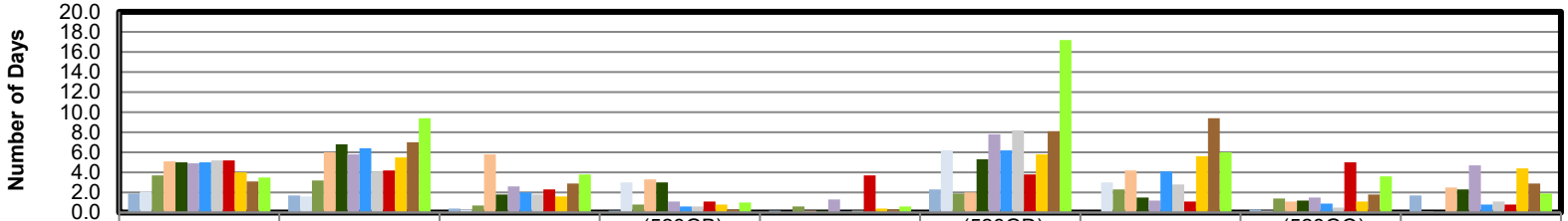
	All VHA	(528) Buffalo, NY	(528A4) Batavia, NY	(528GB) Jamestown, NY	(528GC) Dunkirk, NY	(528GD) Niagara Falls, NY	(528GK) Lockport, NY	(528GQ) West Seneca, NY	(528GR) Olean, NY
APR-FY20	3.6	0.0	7.3	n/a	0.0	2.0	n/a	n/a	n/a
MAY-FY20	4.0	0.0	0.0	n/a	n/a	0.0	n/a	0.0	n/a
JUN-FY20	4.9	2.1	0.0	0.0	0.5	n/a	0.0	0.0	0.0
JUL-FY20	5.9	8.3	1.3	4.0	0.0	n/a	0.2	0.2	0.0
AUG-FY20	5.6	7.5	5.0	7.0	0.0	0.0	2.0	2.3	0.0
SEP-FY20	6.1	6.5	5.6	2.1	0.0	2.5	1.8	6.4	2.4
OCT-FY21	6.3	4.0	2.6	1.1	0.0	2.0	0.2	2.9	0.0
NOV-FY21	6.7	8.5	3.5	0.0	0.0	n/a	1.5	1.3	0.0
DEC-FY21	6.6	6.3	5.0	2.3	2.2	10.3	3.0	0.6	1.8
JAN-FY21	4.4	3.9	2.8	2.0	0.0	3.3	0.9	0.0	0.0
FEB-FY21	2.9	9.2	0.0	0.4	0.5	3.1	0.2	0.7	0.0
MAR-FY21	2.9	5.9	1.6	1.7	0.6	3.7	2.3	1.3	0.0

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019. (This is an internal website not publicly accessible.)

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (528QA) Buffalo Main Street, NY, and (528QB) Packard, NY, as no data were reported. Data was not available for May-FY 2020 for (528GC) Dunkirk, NY.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	All VHA	(528) Buffalo, NY	(528A4) Batavia, NY	(528GB) Jamestown, NY	(528GC) Dunkirk, NY	(528GD) Niagara Falls, NY	(528GK) Lockport, NY	(528GQ) West Seneca, NY	(528GR) Olean, NY
APR-FY20	1.9	1.7	0.4	0.2	0.2	2.3	n/a	0.3	1.7
MAY-FY20	2.1	1.6	0.3	3.0	0.0	6.2	3.0	0.2	0.1
JUN-FY20	3.7	3.2	0.7	0.8	0.6	1.9	2.3	1.4	0.0
JUL-FY20	5.1	6.0	5.8	3.3	0.2	2.0	4.2	1.1	2.5
AUG-FY20	5.0	6.8	1.8	3.0	0.2	5.3	1.5	1.2	2.3
SEP-FY20	4.9	5.8	2.6	1.1	1.3	7.8	1.2	1.5	4.7
OCT-FY21	5.0	6.4	2.0	0.6	0.1	6.2	4.1	0.9	0.8
NOV-FY21	5.2	4.1	1.8	0.6	0.2	8.2	2.8	0.5	1.1
DEC-FY21	5.2	4.2	2.3	1.1	3.7	3.8	1.1	5.0	0.8
JAN-FY21	4.0	5.5	1.6	0.8	0.4	5.8	5.6	1.1	4.4
FEB-FY21	3.1	7.0	2.9	0.3	0.3	8.1	9.4	1.8	2.9
MAR-FY21	3.5	9.4	3.8	1.0	0.6	17.2	6.0	3.6	1.9

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019. (This is an internal website not publicly accessible.)

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (528QA) Buffalo Main Street, NY, and (528QB) Packard, NY, as no data were reported

Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." 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 (HCAHPS)	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
Diabetes (DMG90_ec)	HEDIS outpatient performance measure composite for diabetes care	A higher value is better than a lower value
ED throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Healthcare associated infections	A lower value is better than a higher value
Hospital rating (HCAHPS)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Inpt global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value

Measure	Definition	Desired Direction
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	A higher value is better than a lower value
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH population coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	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 (SS)	Short-stay measure: percent of residents who were re-hospitalized after a nursing home admission.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 23, 2022

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

Subj: Comprehensive Healthcare Inspection of the VA Western New York Healthcare System in Buffalo

To: Director, Office of Healthcare Inspections (54CH02)

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

Thank you for the opportunity to review the OIG draft report, Comprehensive Healthcare Inspection of the VA Western New York Healthcare System in Buffalo, New York. I concur with the report findings and recommendations.

(Original signed by:)

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

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: February 22, 2022

From: Executive Director, VA Western New York Healthcare System (528/00)

Subj: Comprehensive Healthcare Inspection of the VA Western New York Healthcare System in Buffalo

To: Joan E. McInerney, MD, MBA, MA, FACEP, Network Director, New York/New Jersey VA Healthcare Network (10N2)

I have reviewed the attached Draft Report for the CHIP Review of the VA Western New York Healthcare System, Buffalo, NY and concur with this report.

I have reviewed the action plans and concur with them as submitted. VA Western New York Healthcare System will continue to monitor and report as required.

(Original signed by:)

Michael Swartz
Executive Director
VA Western New York Healthcare System

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