DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Syracuse VA Medical Center in New York

CHIP REPORT | REPORT #21-00294-128 | APRIL 19, 2022

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Figure 1. *Syracuse VA Medical Center in New York.*

Source: https://www.va.gov/directory/guide/facility.asp?id=130 (*accessed March 24, 2022*).

Abbreviations

ADPNS	Associate Director for Patient and Nursing Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
EKG	Electrocardiogram
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
PMDB	Prevention and Management of Disruptive Behavior
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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

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

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

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the medical center's leadership team consisted of the Medical Center Director, Chief of Staff, Associate Director for Patient and Nursing Services, and the Associate Director. Organizational communications and accountability were managed through a committee reporting structure, with Leadership Council oversight of several working groups. Leaders monitored patient safety and care through the Quality Improvement Leadership Committee, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's leaders had worked together for about five months, although the Chief of Staff and Associate Director for Patient and Nursing Services had served in their positions for over five years. The Director was permanently assigned in August 2020. The Associate Director, who was assigned in January 2021, was the newest member of the leadership team.

The OIG reviewed survey results and generally found that scores for the medical center were less favorable than VHA averages, while scores for the Chief of Staff and Associate Director for Patient and Nursing Services were more favorable. However, the scores demonstrated that leaders have an opportunity to decrease staff feelings of moral distress at work, and the Director has an opportunity to improve servant leadership behavior.[2] Survey results were not available for the Associate Director, who assumed the role after the survey was administered, and are not fully reflective of the current Director, who was assigned one month prior to survey administration. Selected patient experience survey scores highlighted opportunities for leaders to improve female patients' impressions of inpatient doctors treating them with courtesy and respect and their ability to obtain routine specialty care appointments when needed.

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

The inspection team also reviewed accreditation agency findings and did not identify any 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 knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL and Community Living Center 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 reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[7]

[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." 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."

[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.

[7] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions and protected peer reviews.[8] However, the OIG identified weaknesses with the Systems Redesign and Improvement Program and Surgical Work Group.

Medication Management

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

High-Risk Processes

The medical center met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with 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 Medical Center Director, Chief of Staff, and Associate Director for Patient and Nursing Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address system issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

[8] VHA Directive 1190. 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.

VA Comments

The Veterans Integrated Service Deputy Network Director and Medical Center 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.

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

Contents

Purpose and Scope

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

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

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

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

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

[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)

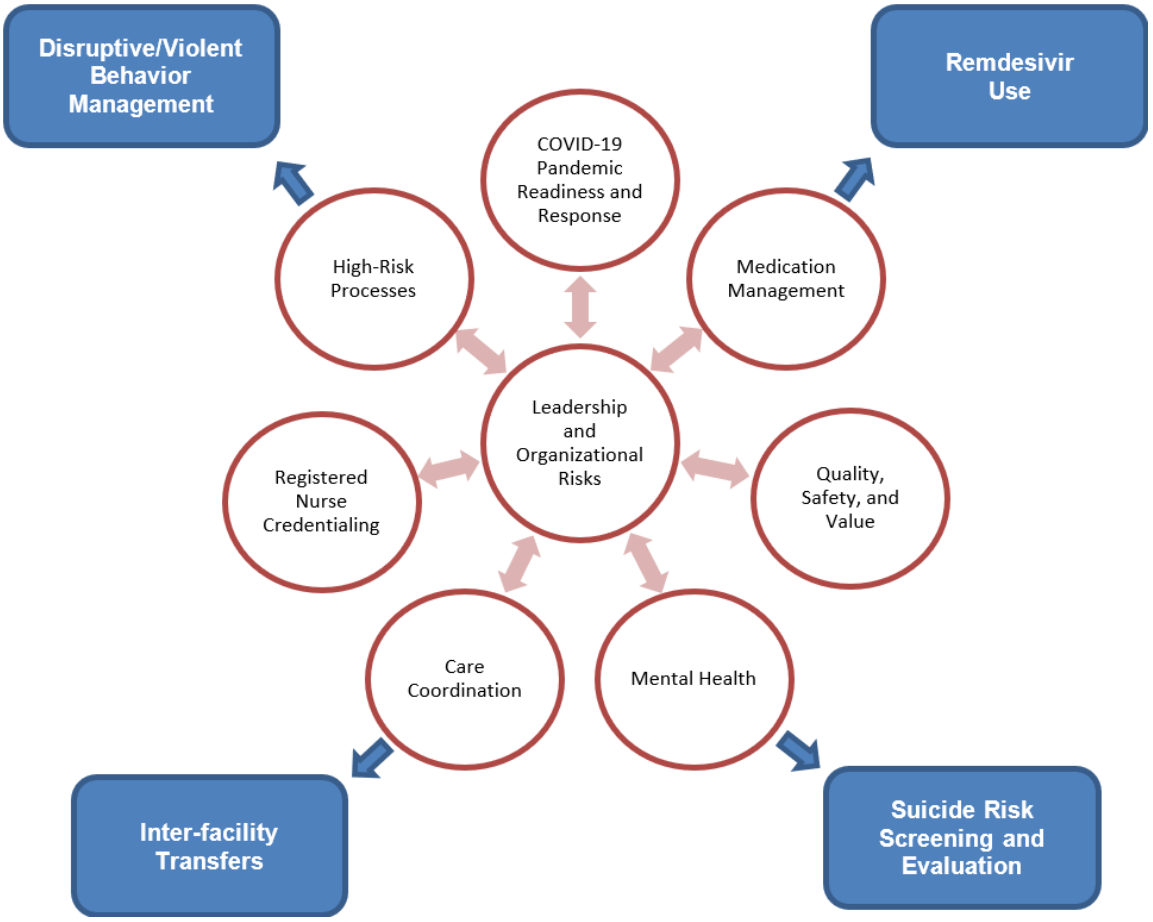


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

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

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

The inspection examined operations from March 27, 2017, 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 reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[8]

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

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

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

---

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

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

[8] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

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

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the medical center response
8. VHA performance data (medical center)
9. VHA performance data (community living center (CLC))[11]

Executive Leadership Position Stability and Engagement

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

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

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

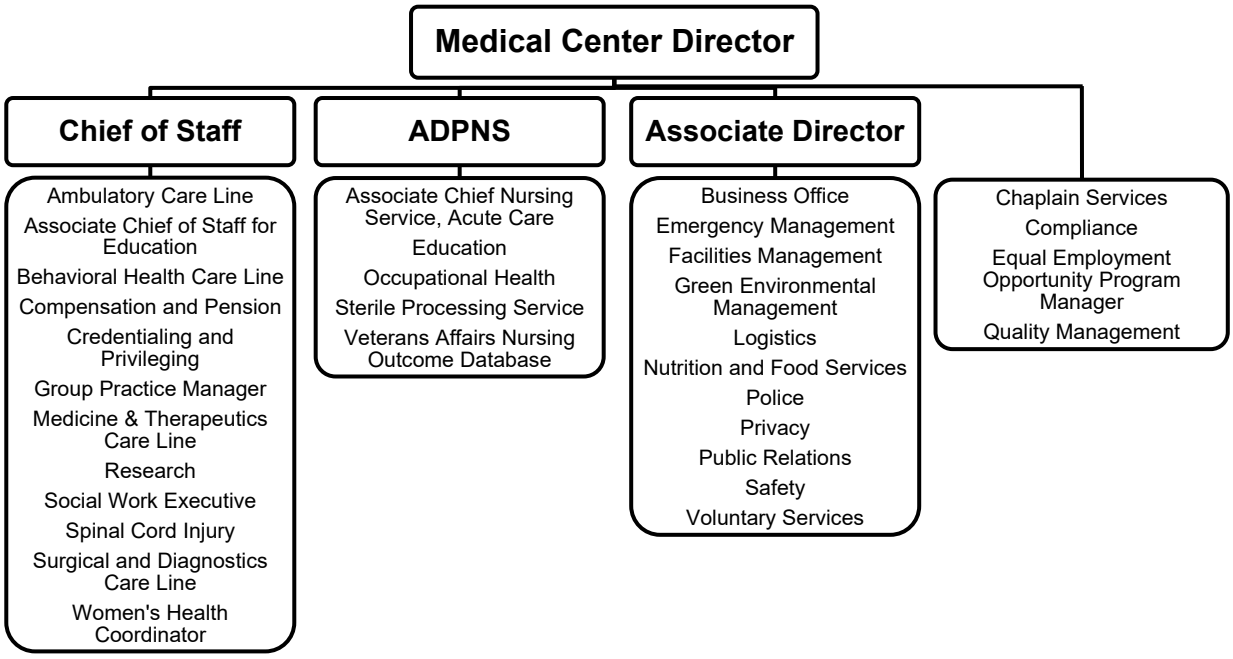


Figure 3. *Medical center organizational chart.*

Source: Syracuse VA Medical Center (received June 23, 2021).

At the time of the OIG inspection, the executive team had worked together for about five months, although the Chief of Staff and ADPNS had served in their roles since July 2015 and April 2016, respectively. The Director was permanently assigned in August 2020, and the Associate Director, assigned in January 2021, was the newest member of the leadership team (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	August 16, 2020
Chief of Staff	July 12, 2015
Associate Director for Patient and Nursing Services	April 17, 2016
Associate Director	January 9, 2021 (acting); January 31, 2021 (permanent)

Source: Syracuse VA Medical Center Senior Strategic Business Partner (received June 25, 2021).

The Director served as the chairperson of the Leadership Council, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Leadership Council oversaw various working groups such as the Nurse Professional Council and the Medical Staff Executive, Quality Improvement Leadership, and Environment of Care Committees. These leaders monitored patient safety and

care through the Quality Improvement Leadership Committee, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

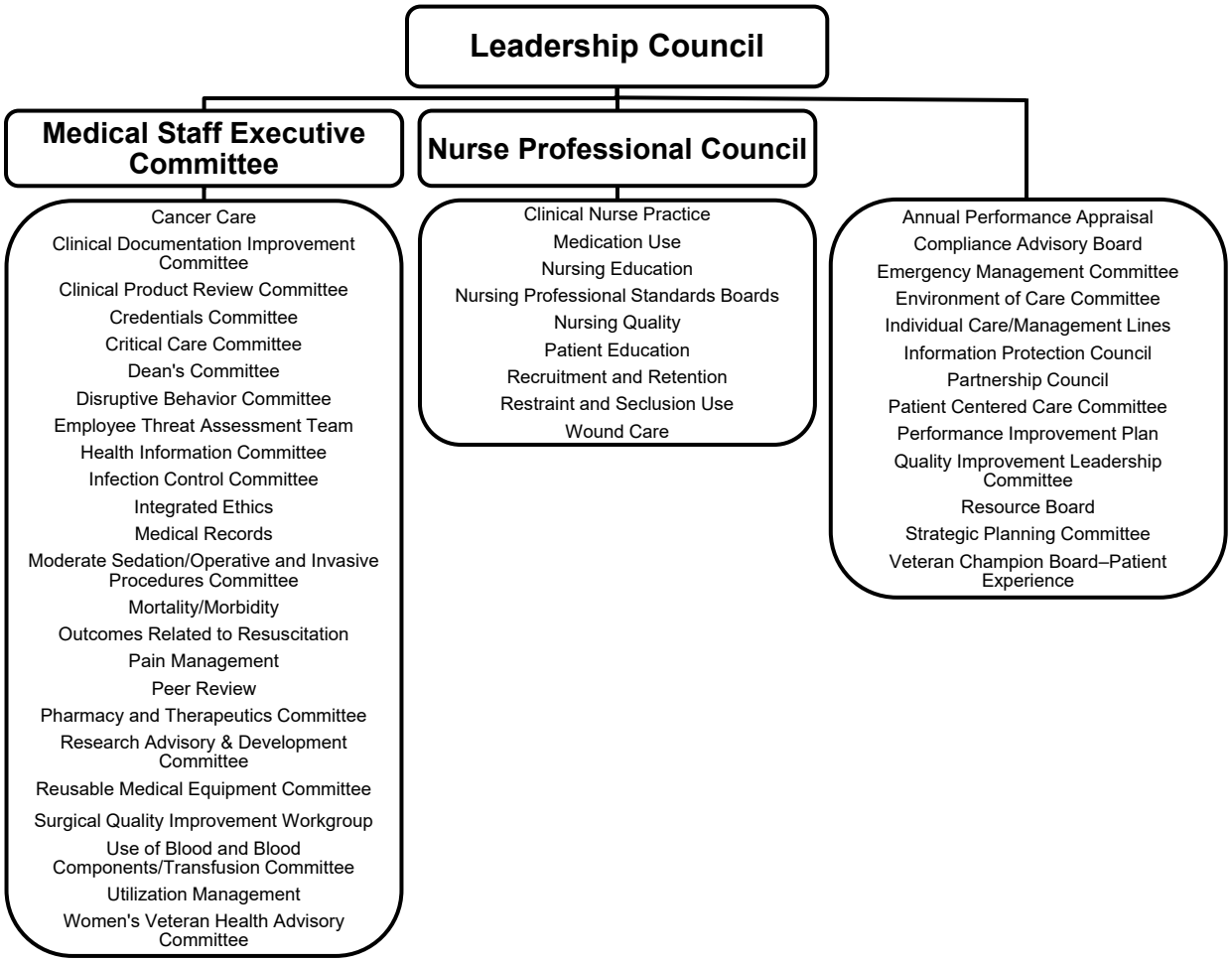


Figure 4. *Medical Center committee reporting structure.*
Source: Syracuse VA Medical Center (received June 24, 2021).

To help assess the medical center 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 performance. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The medical center's FY 2020 annual medical care budget of $420,806,190 increased approximately 10 percent compared to the previous year's budget of $383,649,078.[12] When asked about the effect of this change on the medical center's operations, the Director reported believing the increase helped to address unexpected pandemic needs and various medical center projects.

Staffing

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

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[16] The executive leaders acknowledged the occupations listed in table 2 and reported that some clinical and nonclinical occupational shortages had changed. The Chief of Staff reported difficulties recruiting specialty physicians, like cardiologists, gastroenterologists, and subspecialty surgeons, because VA salaries are generally not competitive with the market. The Chief of Staff further discussed using strategies such as recruitment and retention incentives, special salary rates, and fee-for-service agreements based on occupational need. The ADPNS reported using salary flexibilities to recruit nurses and medical technologists.

[12] VHA Support Service Center.

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

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

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

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

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Vocational Rehabilitation	1. Biomedical Engineering
2. Nurse	2. Police
3. Nurse Anesthetist	3. Air Conditioning Equipment Mechanic
4. Medical Technologist	4. Materials Handler
5. General Health Science/Registered Respiratory Therapist	5. Electrician

Source: VA OIG.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[17] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[18] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[19] The 2020 All Employee Survey results were not available for the Associate Director, who assumed the role after the survey was administered. In addition, survey results are not fully reflective of the current Director, who was assigned only one month prior to survey administration.

Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. The OIG found the medical center averages for the selected survey leadership questions were lower than VHA averages.[20] The Director's survey results demonstrated an opportunity to improve servant leadership, while scores related to the Chief of Staff and ADPNS were consistently higher than those for VHA and the medical center.

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

[18] "AES Survey History."

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

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

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPNS Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	71.6	68.6	86.1	78.0
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.2	3.4	4.1	4.2
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	3.4	4.3	4.3
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	3.6	4.2	4.5

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 medical center averages for the selected survey questions were similar to the VHA averages. For two of the three questions, survey scores for the Director were similar to VHA and medical center averages, and scores for the Chief of Staff and ADPNS were better. However, opportunities appeared to exist for all three leaders to decrease 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).

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

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPNS 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	3.7	4.6	4.7
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	3.7	4.3	4.5
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	1.7	2.0	2.2

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

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[22] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[23]

The Director discussed the strategies implemented from VA's "Stand Up to Stop Harassment Now!" campaign and reported signing the pledge for the campaign to demonstrate commitment

[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!"

to a culture of safety.[24] In addition, the Director described including diversity and inclusion training during town halls and holding regular meetings with the Equal Employment Opportunity Coordinator to discuss strategies for encouraging employees to speak up as a part of a "Just Culture."[25]

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. Except for the opportunity for the Director to improve perceptions of workplace discrimination, the executive leaders' averages for the selected survey questions were similar to or better than VHA averages and conveyed the maintenance of an environment where staff felt respected and safe, and discrimination was not tolerated.

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPNS Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.8	3.9	4.3	4.3
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.1	3.8	4.7	4.5
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	3.8	4.2	4.3

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

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through September 30, 2020. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences

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

[25] "Understand Just Culture," Agency for Healthcare Research and Quality, accessed January 11, 2022, https://www.ahrq.gov. "Just Culture" refers to an environment where employees feel comfortable reporting errors and are held accountable for their actions but not responsible for system failures.

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 (primary care), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the Syracuse VA Medical Center.[26] For this medical center, overall patient satisfaction survey results reflected consistently higher care ratings than the VHA averages. Patients appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	75.2
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	88.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	90.3

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

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

by 2048.[27] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). Patient experience survey scores highlighted opportunities for leaders to improve female patients' perceptions of inpatient doctors treating them with courtesy and respect, and their ability to obtain routine specialty care appointments when needed. Medical center leaders appeared to be actively engaged with male and female patients (for example, by embracing the "I Am Not Invisible" and "Own the Moment" initiatives and implementing a noise reduction process on all inpatient units).[28]

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

[28] "Center for Women Veterans (CWV): I Am Not Invisible," Center for Women Veterans, accessed October 12, 2021, https://www.va.gov/womenvet/iani/index.asp. "I Am Not Invisible (IANI) aims to increase awareness and dialogue about women Veterans." VHA Directive 1003, *VHA Veteran Patient Experience,* April 14, 2020. "Own the Moment (OTM) is a principles-based approach to meet the needs of the Veteran and provide exceptional Veteran Patient Experience. The three principles of OTM align with the VA Customer Experience Principles: Connect and Care (Emotion), Understand & Respond to Needs (Effectiveness), and Guide the Journey (Ease)."

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	75.4	69.8
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	84.2	83.6
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	86.9	93.0

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

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

† *The medical center averages are based on 427 or 428 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*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	61.6	66.0
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	69.7	54.5
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	80.5	83.6

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

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

†*The medical center averages are based on 643–1,971 male and 52–124 female respondents, depending on the question.*

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	53.7	54.7
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	66.2	52.5
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	79.3	81.7

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

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

† *The medical center averages are based on 369–1,255 male and 16 –54 female respondents, depending on the question.*

Accreditation Surveys and Oversight Inspections

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

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

OIG and The Joint Commission (TJC).[30] At the time of the OIG inspection, the medical center had closed all recommendations for improvement issued since the previous Clinical Assessment Program site visit conducted in March 2017. In May 2021, the medical center had an initial TJC laboratory review, which resulted in 13 recommendations. Quality management staff reported that the medical center's action plans were due in July 2021.

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities.[31] Additional results included the Long Term Care Institute's inspection of the CLC and the Paralyzed Veterans of America's inspection of the spinal cord injury/disease unit and related services.[32]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Clinical Assessment Program Review of the Syracuse VA Medical Center, Syracuse, New York*, Report No. 16-00558-311, August 7, 2017)	March 2017	13	0
TJC Hospital Accreditation	September 2018	21	0
TJC Behavioral Health Care Accreditation		6	0
TJC Home Care Accreditation		7	0
TJC VA Healthcare Network Upstate New York at Syracuse–Lab	May 2021	13	13

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

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

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

[32] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long-Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings." The Paralyzed Veterans of America inspection took place August 14–15, 2018. This veterans service organization review does not result in accreditation status.

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

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

Table 11 lists the reported patient safety events from March 27, 2017 (the prior OIG Clinical Assessment Program site visit), through June 21, 2021.[33]

Table 11. Summary of Selected Organizational Risk Factors (March 27, 2017, through June 21, 2021)

Factor	Number of Occurrences
Sentinel Events	1
Institutional Disclosures	9
Large-Scale Disclosures	0

Source: Syracuse VA Medical Center's acting Patient Safety Manager, Risk Management Specialist, and Chief of Staff (received June 22–23, 2021).

The Director spoke knowledgeably about serious adverse event reporting and explained that staff complete an investigation using the root cause analysis process, with the Risk Manager informing the Director and Chief of Staff of the results and recommended actions. In addition, a multidisciplinary team reviews specific adverse events and looks for improvement opportunities

[33] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The Syracuse VA Medical Center is a mid-high complexity (1c) 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."

and lessons learned that can be shared throughout the medical center. The Director reported that quality management staff are responsible for tracking and following up on corrective actions resulting from an adverse event, as well as updating the executive leaders. For institutional disclosures, the Director stated that the Risk and Performance Managers complete an investigation and discuss the event with the Chief of Staff. The Chief of Staff described reviewing each case, along with the subspecialty service chief, if warranted, and discussing selected cases with the VISN Chief Medical Officer. The Chief of Staff further explained that the events were discussed with the Director and legal counsel prior to any institutional disclosure.

Although leaders were able to discuss the adverse event reporting process, the OIG identified concerns related to staff identifying sentinel events and conducting institutional disclosures for those events. These concerns are discussed in greater detail in the findings and recommendations section.

Veterans Health Administration Performance Data for the Medical Center

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[34] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[35]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the Syracuse 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, rating (of) patient-centered medical home (PCMH) provider, mental health (MH) continuity (of) care, stress discussed, and rating (of) specialty care (SC) provider). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (emergency department (ED) throughput, adjusted length of stay (LOS), Centers for Medicare & Medicaid Services (CMS) mortality (MORT), and inpatient (Inpt) global measures (GM90_1)).[36] The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures.

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

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

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

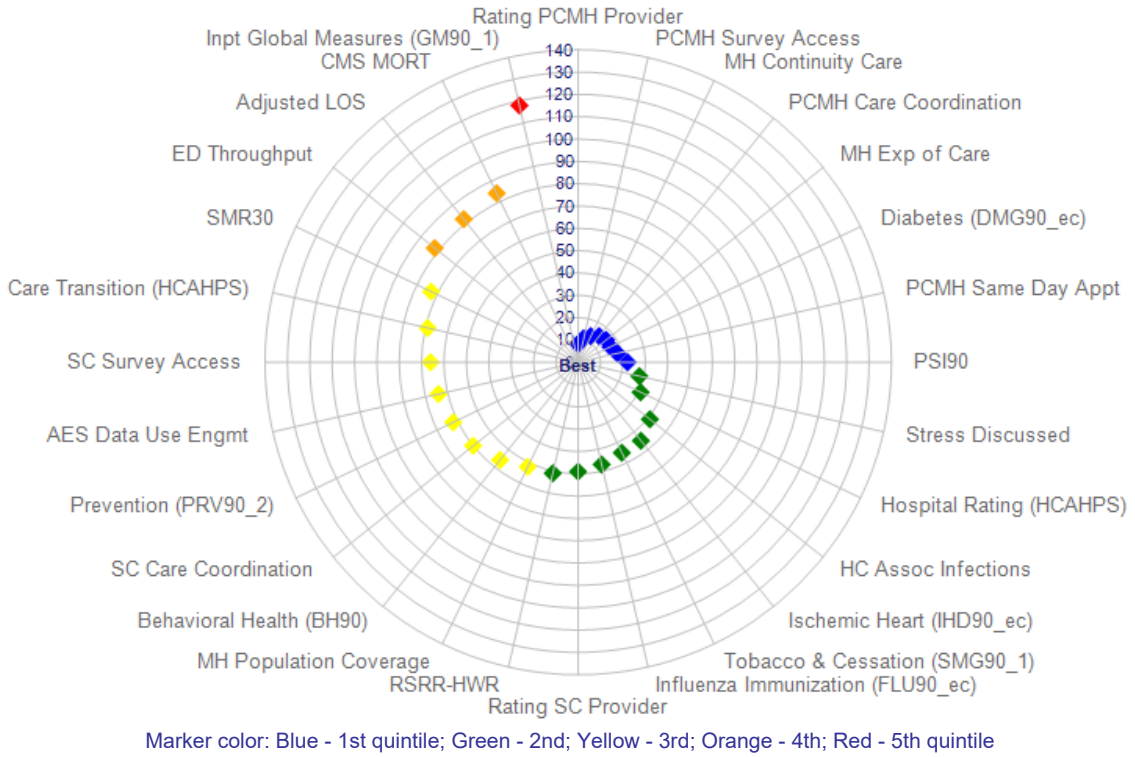


Figure 5. *Medical center quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 2020).*

Source: VHA Support Service Center.

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

Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[37] The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[38]

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

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

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. Figure 6 displays the CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, catheter in bladder–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), rehospitalized after nursing home (NH) admission (SS), and ability to move independently worsened (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, falls with major injury (LS), help with activities of daily living (ADL) (LS), outpatient emergency department (ED) visit (SS), and urinary tract infection (UTI) (LS)).[39] The executive leaders verbalized understanding within their scope of responsibility about the specific CLC SAIL measures that needed improvement.

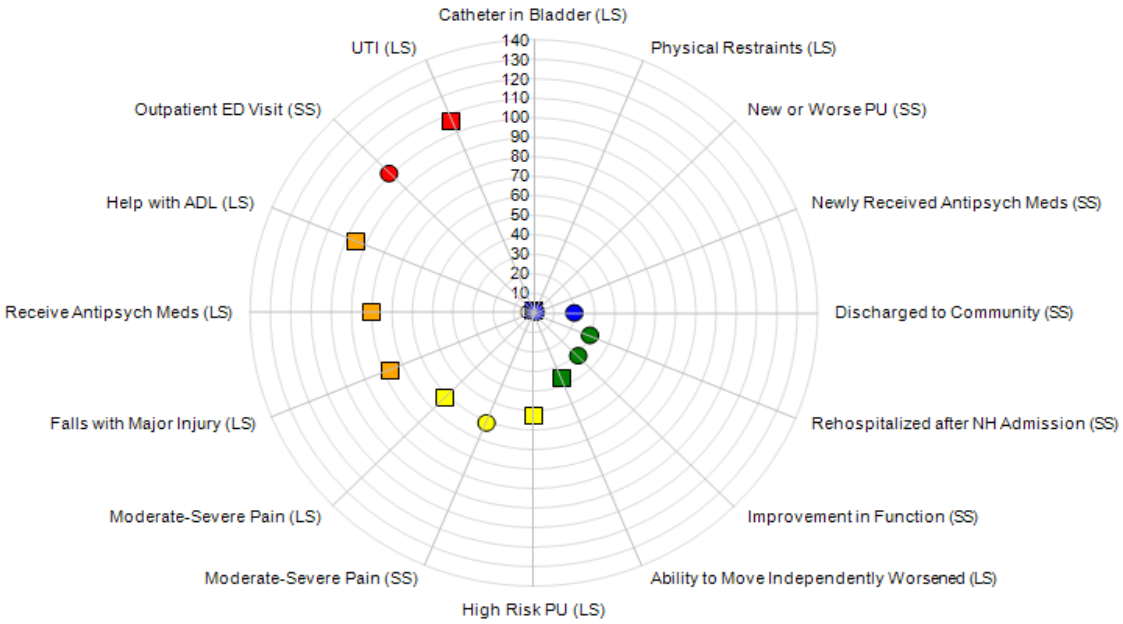


Figure 6. *Syracuse CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).*
LS = Long-Stay Measure. *SS = Short-Stay Measure.*
Source: VHA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG virtual inspection, all of the medical center's executive leadership team positions were permanently assigned. The leaders had worked together for about five months, although the Chief of Staff and ADPNS had served in their positions for more than five years.

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

The Director and Associate Director were the newest members of the leadership team, permanently assigned in August 2020 and January 2021, respectively.

The Director served as the chairperson of the Leadership Council, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The medical center's FY 2020 annual medical care budget increased approximately 10 percent compared to the previous year. The executive leaders verbalized understanding and support of the medical center's process improvement activities and discussed interim strategies to address clinical and nonclinical occupational shortages.

Selected employee satisfaction survey responses revealed satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated. However, responses also pointed to opportunities for leaders to decrease employee feelings of moral distress at work. Patient experience survey data indicated opportunities for leaders to improve female patients' perceptions of inpatient doctors treating them with courtesy and respect and their ability to get routine specialty care appointments when needed.

The executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models. The OIG's review of the medical center's accreditation findings did not identify any substantial organizational risk factors. However, the OIG identified a concern within the patient safety and risk management programs.

TJC defines a sentinel event as a "category of patient safety events that reaches the patient and results in death, severe temporary or permanent harm."[40] TJC expects accredited facilities to identify, investigate, and disclose sentinel events to the patient or family.[41] In support of TJC, VHA established the Patient Safety Program to develop a system 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.[42] 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.[43] Furthermore, VHA recognizes that the disclosure of harmful events is "consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence" and requires leaders to inform or disclose to a patient or patient's personal representative when a sentinel event occurs.[44] VHA also requires

[40] "Sentinel Event Policy and Procedures," The Joint Commission, accessed March 2, 2021, https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-policy-and-procedures/.

[41] "Sentinel Event Policy and Procedures."

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

[43] VHA Handbook 1050.01.

[44] VHA Directive 1004.08.

leaders to communicate the disclosure to the patient's representative if the patient is deceased or unable to participate.[45]

The OIG requested information on sentinel events and institutional disclosures from March 27, 2017, through June 21, 2021. The Risk Manager reported that leaders conducted nine institutional disclosures. However, the OIG found that staff did not properly identify seven of nine disclosed occurrences as sentinel events, and that five of these seven sentinel events involved a delay in cancer diagnosis and treatment. 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 Patient Safety Manager could not explain why these seven adverse events were not identified as sentinel events but provided evidence that two of the five cancer diagnosis and treatment delay cases were peer-reviewed while the rest were reportedly "reviewed." The OIG also examined evidence that three of the five cases resulted in the development of new facility policies or processes.

The OIG also received information for one sentinel event, which involved a patient who died during an invasive procedure. The OIG did not find evidence that leaders conducted an institutional disclosure as required. Failure to perform an institutional disclosure can erode VA's core values and reduce patients' trust in the organization. The quality management team explained that staff completed a peer review and a root cause analysis after the surgeon relayed the event to the patient's spouse.

Recommendation 1

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

[45] VHA Directive 1004.08.

Medical center concurred.

Target date for completion: August 31, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. The Patient Safety Manager will review all adverse events entered in the Joint Patient Safety Reporting (JPSR) system to determine if sentinel event criteria were met according to The Joint Commission sentinel event and VHA National PS [Patient Safety] Handbook criteria. The Patient Safety Manager will maintain a list of all identified sentinel events to ensure all sentinel events have an institutional disclosure. Monthly monitoring will occur to ensure compliance is achieved for six consecutive months.

Reporting: The Patient Safety Manager will report monthly to the Leadership Council the total number sentinel events per month and the total number of corresponding institutional disclosures completed.

Frequency of Monitoring: Monthly monitoring will continue until compliance is sustained at 100 percent for six consecutive months.

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that leaders conduct institutional disclosures for all sentinel events.

Medical center concurred.

Target date for completion: August 31, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. The Patient Safety Manager will provide a list of all identified sentinel events to the Risk Manager. The Risk Manager will review each sentinel event with the Chief of Staff to ensure an institutional disclosure is conducted. The Risk Manager will maintain a list of all institutional disclosures to ensure all sentinel events have an institutional disclosure. Monthly monitoring will occur to ensure compliance is achieved for six consecutive months.

Reporting: The Risk Manager will provide a monthly compliance rate for the number of sentinel events identified and the number of corresponding institutional disclosures completed for those events to the Leadership Council.

Frequency of Monitoring: Monthly monitoring will continue until compliance is sustained at 100 percent for six consecutive months.

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.[46] 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.[47]

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."[48] "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."[49]

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

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

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

[46] "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.

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

[48] 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the "[p]rovision of hospital care and medical services during certain disasters and emergencies...During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[49] 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 reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[50]

[50] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

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.[51] 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.[52] 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."[53]

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

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

The OIG reviewers also assessed the medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[54] 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."[55] 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

[51] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[52] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[53] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.
[54] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.
[55] VHA Directive 1026.01.

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[56] 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."[57] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[58] 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[59]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[60]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[61] 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;

[56] 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."

[57] VHA Directive 1190.

[58] VHA Directive 1190.

[59] VHA Directive 1190.

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

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[62] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[63]

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.[64]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions and protected peer reviews. However, the OIG identified weaknesses with the Systems Redesign and Improvement Program and Surgical Work Group.

VHA requires a systems redesign and improvement coordinator to participate on the VISN Systems Redesign Review Advisory Group to review program data and information.[65] The OIG reviewed VISN Systems Redesign Review Advisory Group meeting minutes from June 2020 through May 2021 and found that the Systems Redesign Coordinator did not participate in 6 of 20 meetings (30 percent). The lack of participation could have hindered VISN leaders' oversight of the medical center's program and resulted in missed opportunities to receive support for identified improvement needs. The Systems Redesign Coordinator reported that time off and competing priorities contributed to inconsistent attendance at VISN Systems Redesign Review Advisory Group meetings.

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

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

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

[65] VHA Directive 1026.01.

Recommendation 3

3. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures the Systems Redesign Coordinator consistently participates in Veterans Integrated Service Network Systems Redesign Review Advisory Group meetings.

Medical center concurred.

Target date for completion: September 1, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. The facility posted for a second system redesign and improvement coordinator on March 1, 2021, and selected a candidate for this position. The candidate completed orientation for the position on September 15, 2021. Participation in the VISN systems redesign review advisory group meeting has been at 100% since October 2021.

Reporting: The monitoring of compliance for the System Redesign Coordinator attendance at the VISN system redesign review advisory group meeting will be reported monthly to the Leadership Council.

Frequency of Monitoring: 100% compliance has been sustained for six consecutive months. VISN and Syracuse Leadership request OIG consider closure of this recommendation based on 100% attendance for six consecutive months of monthly minute attendance tracking.

OIG response: The facility requested closure of recommendation 3 and submitted the attendance log from the VISN System Redesign Review Advisory Group meeting, which demonstrated compliance. However, the facility did not provide any supporting documentation for review to determine compliance with reporting monthly to the Leadership Council. Therefore, the OIG did not close the recommendation.

VHA requires medical facilities that have surgery programs to have a surgical work group that meets at least monthly and includes the Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[66] The OIG interviewed managers and requested the medical center's Surgical Work Group meeting minutes for 12 months (June 2020 through May 2021).[67] The OIG did not find evidence that the group met during 5 of 12 months (June through October 2020). For the remaining 7 months, the OIG found that the Chief of Staff did not attend any of the meetings. The lack of monthly meetings and core member attendance could have resulted in missed opportunities for oversight and review of surgery program activities with key staff. The Chief of Surgery stated that the group met monthly but did not

[66] VHA Directive 1102.01(1).

[67] The Performance Manager reported that the name changed from Mortality and Morbidity to the Surgical Work Group but is not yet reflected in their committee chart.

record meeting minutes because it did not have administrative support staff. According to the Chief, the pandemic made it difficult to hire staff for this role. Further, the Chief of Staff reported not attending meetings due to pandemic-related activities and the medical center's reorganization.

Recommendation 4

4. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that the Surgical Work Group meets monthly and core members consistently attend meetings.

Medical center concurred.

Target date for completion: August 31, 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. The Surgical Work Group continues to meet monthly. The meeting day was changed on October 12, 2021, to ensure the Chief of Staff was available to attend. Attendance for all required participants is tracked and documented in the Surgical Work Group minutes by the Surgical Quality Improvement RN [registered nurse] at each monthly meeting.

Reporting Committee: The compliance for monitoring attendance of the required members of the Surgical Work Group is reported monthly by the Chief of Surgery to the Medical Staff Executive Committee.

Frequency of Monitoring: Monthly monitoring until 90 percent compliance is achieved then monitor for six consecutive months for sustainment.

VHA also requires the Surgical Work Group to be responsible for the "monthly review of surgical deaths, an analysis of efficiency and utilization metrics, the review of NSO [National Surgery Office] surgical quality reports, and evaluation of critical surgical events."[68] The OIG interviewed managers and reviewed Surgical Work Group meeting minutes from November 2020 through May 2021 and did not find evidence that the group analyzed efficiency and utilization metrics or critical surgical events. Failure to analyze surgical data may have resulted in missed opportunities to improve patient safety in the surgical program. The Chief of Surgery reported that the Surgical Work Group analyzed metrics and critical surgical events but did not document it due to the lack of administrative support staff to record meeting minutes.

[68] VHA Directive 1102.01(1).

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Surgical Work Group analyzes efficiency and utilization metrics and evaluates critical surgical events.

Medical center concurred.

Target date for completion: August 31, 2022

Medical center response: On February 28, 2022, the Chief of Surgical Services added the National Surgery Office Utilization and Efficiency reports and the Morbidity and Mortality Critical Event Reviews to the monthly Surgical Work Group meeting for analysis and evaluation. Results of the analysis and evaluation will be documented in the monthly Surgical Work Group meeting minutes.

Reporting Committee: The Chief of Surgery will report the monthly compliance rate for documenting analysis and evaluation of efficiency, utilization, and critical event metrics to the Medical Staff Executive Committee.

Frequency of Monitoring: Monthly monitoring until 90 percent compliance is achieved then monthly for six consecutive months for sustainment.

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."[69] 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."[70]

VA requires all RNs to hold at least one active, unencumbered license.[71] 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.[72] 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.[73] 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.[74]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 31 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 31 RNs to determine whether medical center staff completed primary source verification prior to the appointment.

---

[69] 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.

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

[71] 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."

[72] 38 U.S.C. § 7402.

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

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

Registered Nurse Credentialing Findings and Recommendations

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

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[75] 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.[76]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[77] 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.[78]

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."[79] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[80]

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 five 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

---

[75] 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.

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

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

[78] 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.*

[79] 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.

[80] 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)[81]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[82]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the medical center met many elements of expected performance, including the availability of staff to receive remdesivir shipments. However, the OIG identified deficiencies with the completion of required testing prior to medication administration and provision of patient or caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required providers to test all patients' estimated glomerular filtration rate to assess for adequate kidney function prior to remdesivir administration.[83] The OIG found no evidence that providers used the estimated glomerular filtration rate to assess kidney function for two of the five patients who received remdesivir. This could have led to kidney damage or failure. The Chief of Staff reported that providers used the creatinine clearance test because the estimated glomerular filtration rate does not provide a good estimate of kidney function in patients 70 years of age and older. The Chief of Staff added that using the estimated glomerular filtration rate for these patients may lead to dosing errors and adverse drug events.

Also under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to give patients or caregivers the *Fact Sheet for Patients and Parents/Caregivers*; inform them that remdesivir was not an FDA-approved medication; provide the option to refuse the medication; and advise them of known risks, benefits, and alternatives to

[81] "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."

[82] "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.

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

remdesivir prior to administration.[84] Of the five patients who received remdesivir, the OIG determined that healthcare providers did not

- give three patients or caregivers (60 percent) the *Fact Sheet for Patients and Parents/Caregivers,*
- inform three patients or caregivers (60 percent) of the option to refuse remdesivir, and
- advise two patients or caregivers (40 percent) of alternatives to remdesivir.

This could have resulted in patients or caregivers lacking the information needed to make a fully informed decision to receive the medication. The Pharmacy Clinical Coordinator explained that healthcare providers counseled patients who received remdesivir and gave them the *Fact Sheet for Patients and Parents/Caregivers* but did not document the details of their conversation using the specific language outlined in the fact sheet.

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.[85]

[84] VA Pharmacy Benefits Management Services*, Remdesivir Emergency Use Authorization (EUA) Requirements*.
[85] 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.[86] 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.[87] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[88]

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.[89] 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.[90] The OIG assessed the medical center 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;

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

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

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

[89] 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.

[90] 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 47 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

Generally, the medical center met 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.[91]

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."[92] 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.[93]

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

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

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 45 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

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

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

[92] VHA Directive 1094.

[93] 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.

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."[94] 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."[95] 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[96]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[97]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[98]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[99]

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

[95] VHA Directive 2012-026.

[96] 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."

[97] 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."

[98] 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."

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

VHA requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[100] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[101] 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 the medical center addressed many of the indicators for the management of disruptive and violent behavior. However, the OIG identified deficiencies with Disruptive Behavior Committee meeting attendance and staff training.

VHA requires that the Chief of Staff and Nurse Executive (ADPNS) establish a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety or risk management, patient advocacy, and the Union Safety Committee.[102] 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 COS [Chief of Staff] other actions related to the problem of patient violence."[103]

The OIG reviewed Disruptive Behavior Committee meeting attendance for June 2020 through May 2021 and found that administrative support staff did not attend any of the meetings. Additionally, the OIG found that the Prevention and Management of Disruptive Behavior Program representative was absent at 4 of 12 meetings (33 percent). This could have resulted in the committee taking a less comprehensive approach when assessing patients' disruptive behavior and carrying out other responsibilities. The Chair of the Disruptive Behavior Committee reported being unaware of the requirement for the committee to include

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

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

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

[103] VHA Directive 2010-053.

administrative support staff, and that unplanned leave contributed to the Prevention and Management of Disruptive Behavior Program representative's inconsistent attendance.

Recommendation 6

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

Medical center concurred.

Target date for completion: August 31, 2022

Medical center response: The Chief of Staff and Associate Director for Patient and Nursing Services reviewed and evaluated additional reasons for noncompliance and did not discover any additional reasons. The Chair of the Disruptive Behavior Committee will coordinate and track monthly attendance for all required members at the Disruptive Behavior Committee meeting. A monitor log will be used to capture attendance at the beginning of each committee meeting.

Reporting Committee: The compliance rate for all required members of the Disruptive Behavior Committee will be reported monthly to the Medical Staff Executive Committee.

Frequency of Monitoring: Monthly monitoring until 90 percent compliance is achieved for each required member of the Disruptive Behavior Committee then monthly for six consecutive months for sustainment.

VHA requires that staff are assigned the prevention and management of disruptive behavior training part 1 at hire and "additional levels of PMDB [prevention and management of disruptive behavior] training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment."[104] The OIG found that 12 of 17 selected staff (71 percent) who met the criteria for part 2 training did not complete the assigned learning modules. This could have resulted in staff's lack of awareness, preparedness, and precautions when responding to disruptive and violent behavior. The Medical Center Director stated that executive leaders, after consultation with the infection control team, paused in-person training due to the pandemic and had not restarted training at the time of the review.

[104] 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 7

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

Medical center concurred.

Target date for completion: August 31, 2022

Medical center response: The Chief of Staff reviewed and evaluated additional reasons for noncompliance and did not discover any additional reasons. The Prevention and Management of Disruptive Behavior (PMDB) Coordinator will collaborate with all Service Chiefs and Supervisors to ensure all employees complete PMDB trainings based on the risk level for their work area. On February 8, 2022, the PMDB Coordinator offered additional PMDB classes and held train the trainer classes. The PMDB Coordinator will track the number of staff required to complete PMDB trainings based on the risk level assigned and the number of staff who complete the training to ensure compliance.

Reporting Committee: The compliance rate for completion of required PMDB training based on risk level assigned, will be reported monthly to the Medical Staff Executive Committee.

Frequency of Monitoring: Monthly monitoring until 90 percent compliance is achieved for each level of PMDB and then monthly for six consecutive months for sustainment.

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

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed review of eight clinical and administrative areas and provided 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 medical center, 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 Medical Center Director, Chief of Staff, and ADPNS. The intent is for these leaders to use the recommendations as a roadmap 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 medical center response • VHA performance data (medical center) • VHA performance data (CLC)	• Leaders identify adverse events as sentinel events when criteria are met. • Leaders conduct institutional disclosures for all sentinel events.	• 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 reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• The Surgical Work Group analyzes efficiency and utilization metrics and evaluates critical surgical events.	• The Systems Redesign Coordinator consistently participates in VISN Systems Redesign Review Advisory Group meetings. • The Surgical Work Group meets monthly and core members consistently attend meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None

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

Appendix B: Medical Center Profile

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

Table B.1. Profile for Syracuse VA Medical Center (528A7)
(October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
Total medical care budget	$379,172,292	$383,649,078	$420,806,190
Number of:			
• Unique patients	57,902	57,278	50,987
• Outpatient visits	560,530	575,491	532,152
• Unique employees§	1,683	1,700	1,749
Type and number of operating beds:			
• Community living center	33	36	29
• Medicine	50	50	43
• Mental health	13	14	8
• Rehabilitation medicine	3	3	1
• Spinal cord	11	15	9
• Surgery	7	6	7

[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 "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." An affiliated medical center is associated with a medical residency program.

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
Average daily census:			
• Community living center	35	38	34
• Medicine	48	49	44
• Mental health	11	13	9
• Rehabilitation medicine	3	3	2
• Spinal cord	11	13	11
• Surgery	10	8	6

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

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

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

†*October 1, 2018, through September 30, 2019.*

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

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Auburn, NY	528G5	2,869	941	Cardiology Endocrinology Gastroenterology Orthopedics Rheumatology	Electrocardiogram (EKG)	–
Freeville, NY	528G9	4,107	1,061	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Orthopedics Rheumatology	EKG	Nutrition Pharmacy 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
Massena, NY	528GL	3,626	2,929	Cardiology Dermatology Endocrinology Gastroenterology Neurology Podiatry Rheumatology Vascular	EKG Nuclear medicine	Nutrition Prosthetics Weight management
Rome, NY	528GM	12,263	4,933	Cardiology Dermatology Endocrinology Eye Gastroenterology Gynecology Nephrology Neurology Orthopedics Podiatry Rheumatology Vascular	EKG Radiology	Nutrition Pharmacy Prosthetics Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Binghamton, NY	528GN	6,983	2,140	Cardiology Dermatology Endocrinology Eye Gastroenterology Nephrology Neurology Orthopedics Podiatry Rheumatology Vascular	EKG Nuclear medicine	Nutrition Pharmacy Prosthetics Weight management
Watertown, NY	528GO	5,870	3,509	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Neurology Orthopedics Podiatry Rheumatology Vascular	EKG Radiology	Nutrition Pharmacy Prosthetics Weight management

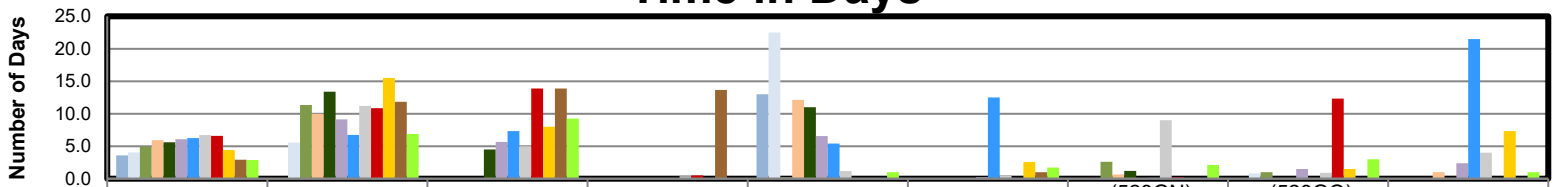
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Oswego, NY	528GP	3,136	985	Dermatology Endocrinology Gastroenterology Nephrology Neurology Rheumatology Vascular	Nuclear medicine	Nutrition Weight management
Syracuse, NY	528QG	–	16,635	Poly-trauma	–	–
Watertown, NY	528QN	–	1,926	Eye Poly-trauma Rehabilitation physician	–	–

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 (528QH) South Salina, NY and (528QI) Erie East, NY as no data were reported.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days



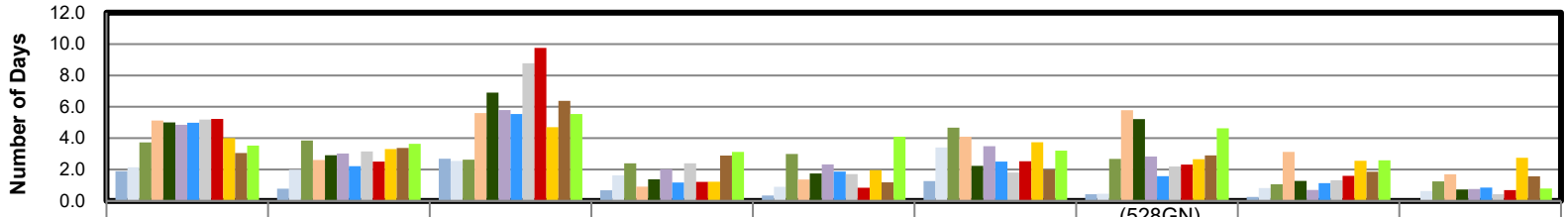
	All VHA	(528A7) Syracuse, NY	(528G5) Auburn, NY	(528G9) Freeville, NY	(528GL) Massena, NY	(528GM) Rome, NY	(528GN) Binghamton, NY	(528GO) Watertown, NY	(528GP) Oswego, NY
APR-FY20	3.6	n/a	n/a	n/a	13.0	0.0	0.0	0.0	n/a
MAY-FY20	4.0	5.6	n/a	n/a	22.5	0.0	0.0	0.8	n/a
JUN-FY20	4.9	11.4	n/a	n/a	0.3	0.0	2.6	1.0	0.0
JUL-FY20	5.9	10.0	0.0	0.0	12.1	0.0	0.7	0.0	1.0
AUG-FY20	5.6	13.4	4.5	0.0	11.0	0.0	1.2	0.0	0.0
SEP-FY20	6.1	9.1	5.7	0.0	6.6	0.2	0.0	1.5	2.4
OCT-FY21	6.3	6.8	7.3	0.0	5.4	12.5	0.1	0.0	21.5
NOV-FY21	6.7	11.2	5.0	0.4	1.2	0.4	9.0	0.9	4.0
DEC-FY21	6.6	10.9	13.9	0.5	0.0	0.0	0.3	12.3	0.0
JAN-FY21	4.4	15.5	8.0	0.0	0.0	2.6	0.0	1.5	7.3
FEB-FY21	2.9	11.8	13.9	13.7	0.0	1.0	0.0	0.0	0.0
MAR-FY21	2.9	6.9	9.3	0.0	1.0	1.7	2.1	3.0	1.0

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 (528QG) Erie West, NY; (528QH) South Salina, NY; (528QI) Erie East, NY; and (528QN) Watertown 2, NY, as no data were reported.

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	(528A7) Syracuse, NY	(528G5) Auburn, NY	(528G9) Freeville, NY	(528GL) Massena, NY	(528GM) Rome, NY	(528GN) Binghamton, NY	(528GO) Watertown, NY	(528GP) Oswego, NY
APR-FY20	1.9	0.8	2.7	0.7	0.4	1.3	0.4	0.3	0.0
MAY-FY20	2.1	2.0	2.5	1.6	0.9	3.4	0.5	0.8	0.6
JUN-FY20	3.7	3.9	2.6	2.4	3.0	4.7	2.7	1.1	1.2
JUL-FY20	5.1	2.6	5.6	0.9	1.4	4.1	5.8	3.1	1.7
AUG-FY20	5.0	2.9	6.9	1.4	1.8	2.2	5.2	1.3	0.7
SEP-FY20	4.9	3.0	5.8	2.0	2.3	3.5	2.8	0.7	0.8
OCT-FY21	5.0	2.2	5.5	1.2	1.9	2.5	1.6	1.1	0.9
NOV-FY21	5.2	3.2	8.8	2.4	1.7	1.8	2.2	1.3	0.4
DEC-FY21	5.2	2.5	9.8	1.2	0.8	2.5	2.3	1.6	0.7
JAN-FY21	4.0	3.3	4.7	1.2	2.0	3.7	2.7	2.6	2.8
FEB-FY21	3.1	3.4	6.4	2.9	1.2	2.0	2.9	1.9	1.6
MAR-FY21	3.5	3.6	5.5	3.1	4.1	3.2	4.6	2.6	0.8

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (528QG) Erie West, NY; (528QH) South Salina, NY; (528QI) Erie East, NY; and (528QN) Watertown 2, 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."

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
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
Care transition (HCAHPS)	Care transition (inpatient)	A higher value is better than a lower 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	Health care associated infections	A lower value is better than a higher value
Hospital rating (HCAHPS)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Inpt global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value

Measure	Definition	Desired Direction
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	A higher value is better than a lower value
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH population coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	Patient-centered medical home (PCMH) care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care, and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value

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

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 1, 2022

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

Subj: Comprehensive Healthcare Inspection of the Syracuse VA Medical Center in New York

To: Director, Office of Healthcare Inspections (54CH06)

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 Syracuse VA Medical Center in Syracuse, New York. I concur with the report findings and recommendations.

(Original signed by:)

Thomas Sharpe, Deputy Network Director, VISN 2
On behalf of
Joan E. McInerney, MD, MBA, MA, FACEP
Network Director, VISN 2

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 28, 2022

From: Director, Syracuse VA Medical Center (528A7/00)

Subj: Comprehensive Healthcare Inspection of the Syracuse VA Medical Center in New York

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

1. We appreciate the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Syracuse VA Health Care System in Syracuse, NY.

2. I have reviewed the recommendations and concur with the responses and actions provided by our team here at the Syracuse VA Health Care System to ensure we continue to deliver excellent care to our Veterans.

(Original signed by:)

Frank P Pearson DPT, PA-C
CAPT, USN (Ret)
U.S. Department of Veterans Affairs
Director, Syracuse Medical Center

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Rachel Agbi, DBA, MSN, Team Leader Priscilla Agali, DNP, FNP-C Kelley Brendler-Hall, MSN, RN Patricia Calvin, MBA, RN
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH, BS Jennifer Frisch, MSN, RN Rose Griggs, MSW, LCSW Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Joy Smith, BS, RDN Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH Robert Wallace, ScD, MPH Elizabeth K. Whidden, MS, APRN

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 2: New York/New Jersey VA Health Care Network
Director, Syracuse VA Medical Center (528A7/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kirsten Gillibrand, Charles Schumer
U.S. House of Representatives: Brian Higgins, Chris Jacobs, John Katko, Joseph Morelle, Tom Reed, Elise Stefanik, Claudia Tenney

OIG reports are available at www.va.gov/oig.