DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 2: New York/New Jersey VA Health Care Network in Bronx, New York

CHIP REPORT | REPORT #21-00240-158 | MAY 31, 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

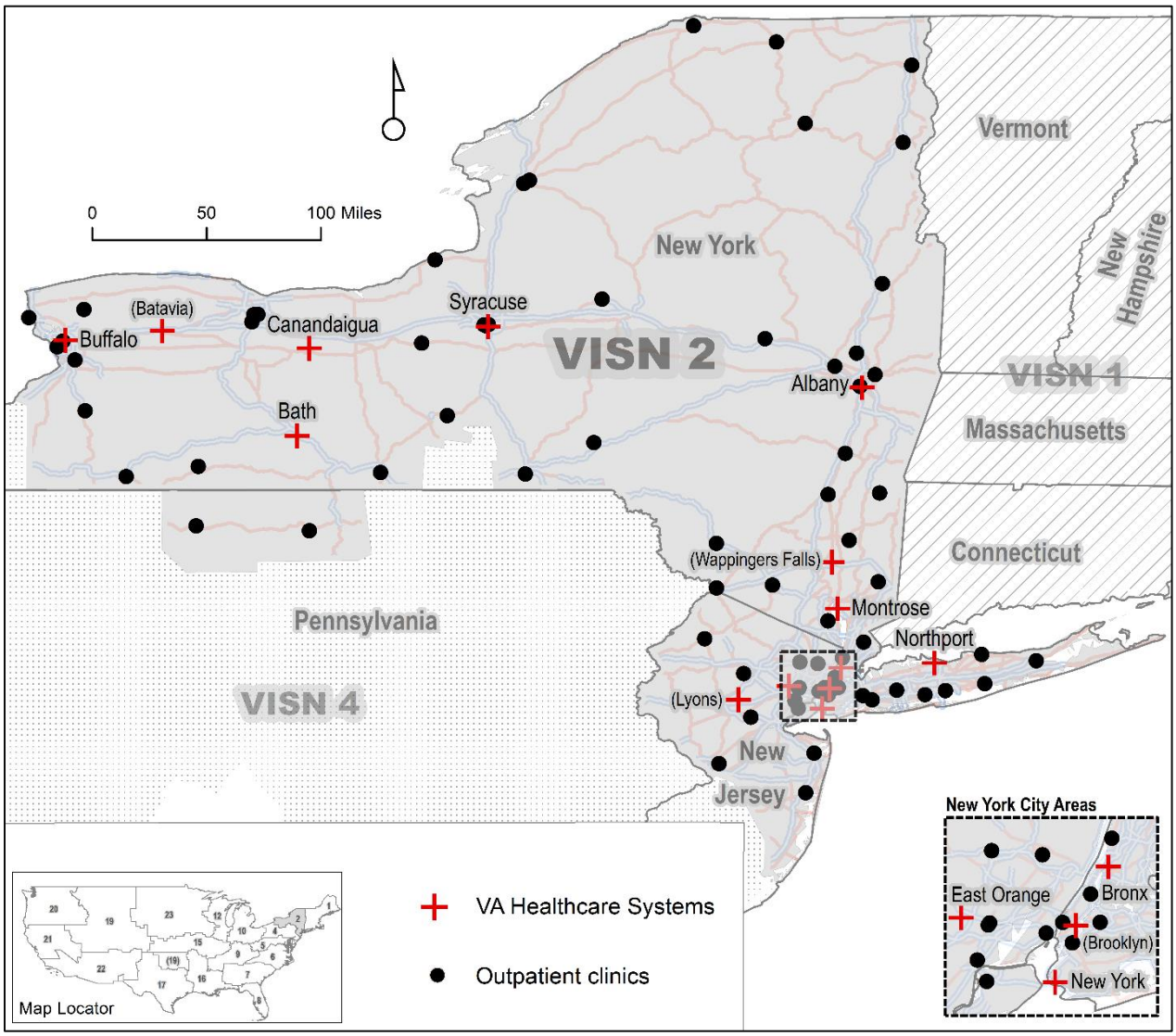

Figure 1. *Veterans Integrated Service Network 2: New York/New Jersey VA Health Care Network.*
Source: Veterans Health Administration Site Tracking System (accessed July 21, 2021).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	Chief Medical Officer
COVID-19	coronavirus disease
FTE	full-time equivalent
FY	fiscal year
HCS	health care system/healthcare system
HRO	Human Resources Officer
OIG	Office of Inspector General
QMO	Quality Management Officer
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by Veterans Integrated Service Network (VISN) 2: New York/New Jersey VA Health Care Network. 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 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 areas:

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

The OIG conducted this unannounced virtual inspection during the week of July 12, 2021. The OIG also performed virtual inspections of the following VISN 2 facilities during the weeks of June 7, 22, and 28, and July 12, 2021:

- VA Finger Lakes Healthcare System (Bath, New York)
- James J. Peters VA Medical Center (Bronx, New York)
- Northport VA Medical Center (New York)
- Samuel S. Stratton VA Medical Center (Albany, New York)
- Syracuse VA Medical Center (New York)
- VA Hudson Valley Health Care System (Montrose, New York)

[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)."

- VA New Jersey Health Care System (East Orange)
- VA NY Harbor Healthcare System (New York)
- VA Western New York Healthcare System (Buffalo)

The OIG held interviews and reviewed clinical and administrative processes related to specific focus areas that affect patient outcomes. The findings presented in this report are a snapshot of VISN 2 and facility performance within the identified focus areas at the time of the OIG inspection. The findings may help VISN leaders identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued four recommendations to the Network Director and Chief Medical Officer. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the VISN leadership team consisted of the Network Director; Deputy Network Director; Chief Medical Officer; Quality Management Officer; Chief, Human Resources Officer; and Chief Fiscal Officer. The VISN had a stable leadership team, with the Quality Management Officer and Chief, Human Resources Officer permanently assigned prior to the integration of VISNs 2 and 3 in 2015. The Network Director was appointed in 2016, the Deputy Network Director and Chief Fiscal Officer in 2018, and the Chief Medical Officer in 2019.

The VISN managed organizational communication and accountability through a committee reporting structure, with Executive Leadership Council oversight of the Healthcare Operations, Healthcare Delivery, Quality Safety & Value, and Organizational Health Councils.

The OIG reviewed selected employee satisfaction and patient experience survey results. The OIG concluded that while some VISN leaders seemed engaged, the Chief, Human Resources Officer and Quality Management Officer had opportunities to improve employee perceptions of servant leadership, respect, discrimination, and psychological safety.[2] The OIG also noted that patients rated their inpatient experiences from VISN 2 facilities lower than Veterans Health Administration patients nationally.

[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 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 evaluated VISN access metrics and clinical vacancies. The team identified potential organizational risks at some facilities, with appointment wait times over 20 days at one medical center and clinical vacancies in specialty care services at others.

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."[3] The leadership team members were knowledgeable within their scope of responsibilities about selected SAIL and Community Living Center SAIL measures. In individual interviews, executive leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG identified opportunities for the Network Director, Chief Medical Officer, and Quality Management Officer to improve their oversight of facility-level quality, safety, and value; care coordination; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 2 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[4]

Medical Staff Credentialing

The OIG identified weaknesses in the review and approval of physicians who had potentially disqualifying licensure actions prior to their VA appointment.

Environment of Care

The VISN complied with most environment of care elements. However, the OIG identified weaknesses with the Emergency Management Committee's annual review of the Emergency and Continuity of Operations Plans; Hazards Vulnerability Analysis; and VISN-wide strengths, weaknesses, priorities, and requirements for improvement.

[3] "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.)

[4] 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.

Women's Health: Comprehensive Care

The OIG observed compliance with most of the elements reviewed but identified weaknesses with the appointment of a lead women veterans program manager and completion of annual site visits.

Conclusion

The OIG conducted a detailed inspection across eight key areas and subsequently issued four recommendations for improvement to the Network Director and Chief Medical Officer. The number of recommendations should not be used as a gauge for the overall quality of care provided within this VISN. The intent is for VISN leaders to use these recommendations to help guide improvements in operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix G, page 53, and the responses within the body of the report for the full text of the Network Director's comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Abbreviations ii

Report Overview iii

Inspection Results iv

Purpose and Scope 1

Methodology 2

Results and Recommendations 4

Leadership and Organizational Risks 4

COVID-19 Pandemic Readiness and Response 24

Quality, Safety, and Value 25

Medical Staff Credentialing 27

Recommendation 1 28

Environment of Care 29

Recommendation 2 31

Mental Health: Suicide Prevention 32

Care Coordination: Inter-facility Transfers 33

Women's Health: Comprehensive Care 34

Recommendation 3 35

Recommendation 4 36

Report Conclusion....38

Appendix A: Comprehensive Healthcare Inspection Program Recommendations....39

Appendix B: VISN 2 Profile....42

Appendix C: Survey Results....43

Appendix D: Office of Inspector General Inspections....45

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions....49

Appendix F: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions....51

Appendix G: VISN Director Comments....53

OIG Contact and Staff Acknowledgments....54

Report Distribution....55

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 2: New York/New Jersey VA Health Care Network. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so they can make informed decisions to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[1] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[2]

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual inspection and initiated a pandemic readiness and response evaluation. As such, to examine risks to patients and the organization, the OIG focused on core processes in the following eight areas of administrative and clinical operations:[3]

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

---

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

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

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

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

Methodology

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

The inspection team examined operations from March 27, 2017, through July 16, 2021, the last day of the unannounced multiday virtual inspection.[5] The OIG also performed inspections of the following VISN 2 facilities during the weeks of June 7, 22, and 28, and July 12, 2021:

- VA Finger Lakes Healthcare System (HCS) (Bath, New York)
- James J. Peters VA Medical Center (VAMC) (Bronx, New York)
- Northport VAMC (New York)
- Samuel S. Stratton VAMC (Albany, New York)
- Syracuse VAMC (New York)
- VA Hudson Valley HCS (Montrose, New York)
- VA New Jersey HCS (East Orange)
- VA NY Harbor HCS (New York)
- VA Western New York HCS (Buffalo)

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 2 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[6]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[7] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[5] The range represents the time from the Clinical Assessment Program review of the Syracuse VAMC to the completion of the unannounced multiday virtual CHIP visit on July 16, 2021 (see appendix D).

[6] 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.

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

within each topic area. The OIG accepted the action plans that network leaders developed based on the reasons for noncompliance.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can affect the ability to provide care in the clinical focus areas.[8] To assess this VISN's risks, the OIG considered the following indicators:

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

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility virtual CHIP visits performed during June and July 2021.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among medical facilities, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is the basic budgetary and planning unit of the veterans' healthcare system.[9]

In January 2015, the VA Secretary announced a plan to realign existing VISNs. The realignment reduced the number of VISNs from 21 to 18 and included the integration of VISN 3 into VISN 2 in October 2015. In May 2016, a permanent VISN 2 Network Director was appointed.

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

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

VISN 2 currently consists of nine HCSs and VAMCs and 64 community-based outpatient clinics and serves more than 500,000 veterans in 76 counties in New York, New Jersey, and Pennsylvania. The facilities offer a wide range of comprehensive inpatient and outpatient medical services that include primary, specialty, nursing home, and domiciliary care, and mental health and rehabilitation services. VISN 2 medical facilities are affiliated with numerous colleges and universities in New York and New Jersey.

According to data from the VA National Center for Veterans Analysis and Statistics, VISN 2 had a veteran population of 967,245 within its borders at the beginning of fiscal year (FY) 2021 and a projected FY 2022 population of 936,205. The FY 2020 annual medical care budget of $3,997,310,611 increased by 11 percent compared to the previous year's budget of $3,598,230,838. Leaders expressed that one of the greatest enterprise risks facing the VISN was its aging infrastructure (one of the oldest in VHA).

The OIG recognizes that the COVID-19 pandemic has caused significant and widespread changes in the delivery of health care services. As a result, productivity data and supporting reports may require further analysis to reach specific actionable conclusions.

VISN 2 had a leadership team consisting of the Network Director; Deputy Network Director; Chief Medical Officer (CMO); Quality Management Officer (QMO); Chief, Human Resources Officer (HRO); and Chief Fiscal Officer. The CMO oversaw facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.[10]

[10] For this VISN, the Network Director is responsible for the directors of the VA Finger Lakes HCS (Bath, New York), James J. Peters VAMC (Bronx, New York), Northport VAMC (New York), Samuel S. Stratton VAMC (Albany, New York), Syracuse VAMC (New York), VA Hudson Valley HCS (Montrose, New York), VA New Jersey HCS (East Orange), VA NY Harbor HCS (New York), and VA Western New York HCS (Buffalo).

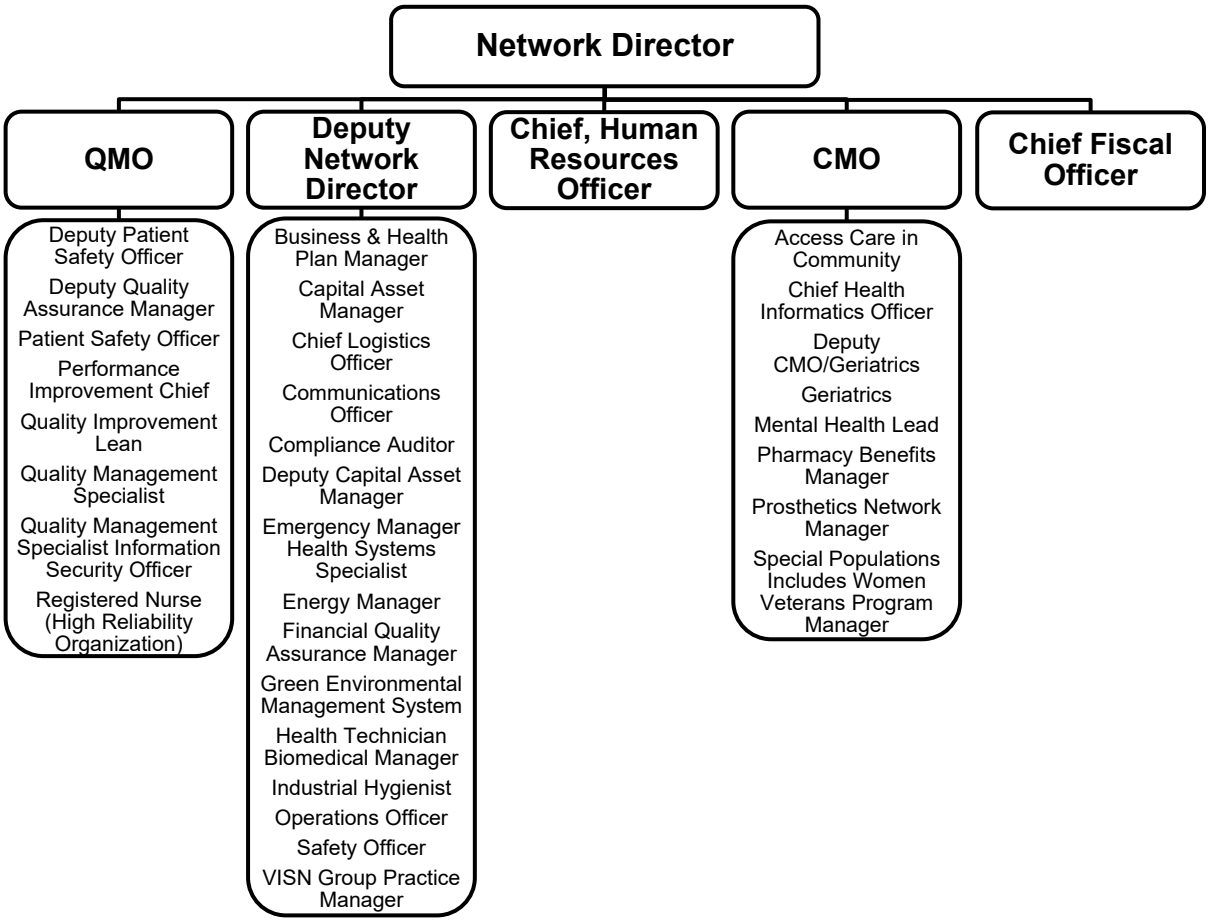

Figure 2. *VISN 2 organizational chart.*

Source: New York/New Jersey VA Health Care Network (received July 12, 2021).

At the time of the OIG virtual inspection, the VISN's leadership team had worked together for almost two years. While the QMO and HRO had held their positions prior to the VISN merger, the Network Director was appointed in May 2016, after the VISN merger. Subsequently, the Deputy Network Director and Chief Fiscal Officer were assigned in 2018, and the CMO, the newest member of the leadership team, was appointed in 2019 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	May 1, 2016
Deputy Network Director	July 8, 2018
Chief Medical Officer	August 18, 2019
Quality Management Officer	May 11, 2008
Chief, Human Resources Officer	March 22, 2015
Chief Fiscal Officer	November 11, 2018

Source: Chief, Human Resources Officer, New York/New Jersey VA Health Care Network (received July 12, 2021).

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

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

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

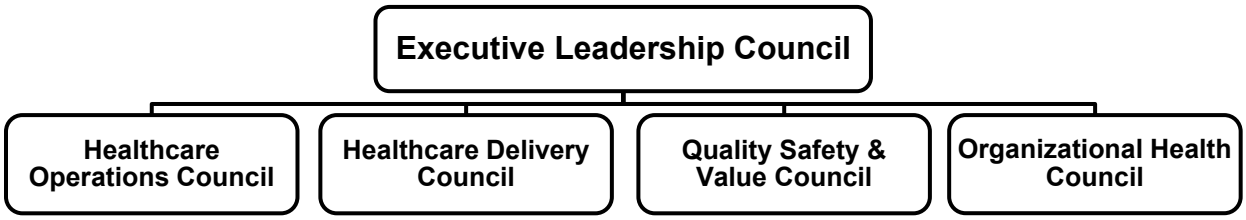

Figure 3. *VISN 2 committee reporting structure.*
Source: New York/New Jersey VA Health Care Network (received July 15, 2021).

To help assess VISN executive leaders' engagement, the OIG interviewed executive leaders regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the leaders spoke knowledgeably about actions taken during the previous 12 months to maintain or improve

organizational performance, employee satisfaction, or patient experiences. Details regarding these actions are below.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[12] 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 with other information on VISN leaders.

To assess employee attitudes toward VISN leaders, the OIG reviewed VHA All Employee Survey satisfaction results from October 1, 2019, through September 30, 2020.[13] Table 2 summarizes those results. The OIG found the VISN office scores were similar to or higher than VHA averages; however, leaders' average scores for the selected survey questions were mixed. The Network Director, Deputy Network Director, and CMO's scores were consistently higher than VHA and VISN averages. While all the scores for the HRO were lower than VHA and VISN averages, both the QMO and HRO had opportunities to improve scores related to servant leader behaviors.[14]

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

Questions/ Survey Items	Scoring	VHA Average	VISN 2 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	77.0	93.3	89.0	93.6	59.4	59.0

[11] "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.)

[12] "AES Survey History."

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

[14] 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.

Questions/ Survey Items	Scoring	VHA Average	VISN 2 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO Average
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	3.6	4.6	4.4	4.4	4.3	3.1
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.8	4.7	4.4	4.6	4.4	3.2
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	4.7	4.5	4.6	4.4	3.3

Source: VA All Employee Survey (accessed May 27, 2021).

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The leaders' averages were mixed when compared to VHA averages. The Network Director, Deputy Network Director, and CMO's scores were consistently better than VHA and VISN averages. However, the QMO and HRO had opportunities to improve employee perceptions of psychological safety and reduce feelings of moral distress. Leaders and staff reportedly analyzed survey results and developed action plans for improvement.

Table 3. Survey Results on Employee Attitudes toward the VISN 2 Workplace (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	VISN Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO 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	3.9	4.3	4.2	4.3	3.9	3.3
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.5	4.5	4.8	3.1	3.3
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.3	0.4	0.9	0.4	1.8	2.8

Source: VA All Employee Survey (accessed May 27, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[15] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop

[15] "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.

Harassment Now!" campaigns to help create a culture of safety where staff and patients felt secure and respected.[16]

Table 4 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The VISN office averages were higher than VHA averages. Scores for the Network Director, Deputy Network Director, and CMO were consistently better than VHA and VISN averages. However, the QMO and HRO had opportunities to improve employee perceptions of respect and discrimination. Leaders and staff again reportedly analyzed survey results and developed action plans for improvement.

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

Questions/Survey Items	Scoring	VHA Average	VISN Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO Average
All Employee Survey: *People treat each other with respect in my workgroup*.	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.1	4.5	4.8	4.9	2.5	3.6
All Employee Survey: *Discrimination is not tolerated at my workplace*.	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.3	4.8	4.9	4.7	3.8	3.6
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues*.	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.0	4.5	4.7	4.8	3.0	3.5

Source: VA All Employee Survey (accessed May 27, 2021).

Patient Experience

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience 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 benchmark its performance against the private sector. VHA collects Survey

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

of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.

The OIG reviewed survey responses to three relevant questions that reflect patients' attitudes toward their healthcare experiences from October 1, 2019, through September 30, 2020. Table 5 provides relevant survey results for VHA and VISN 2.[17] The VISN averages for the selected survey questions were mixed, with inpatient results being slightly lower and both patient-centered medical home and specialty care results being more favorable than VHA averages.

VISN 2 facility scores for the selected survey questions are in appendix C. VISN leaders acknowledged lower-than-average inpatient scores from the VA Hudson Valley HCS, VA New Jersey HCS, and James J. Peters VAMC for the survey question, "Would you recommend this hospital to your friends and family?" VISN leaders made efforts to improve overall inpatient scores by having discussions with facility directors and identifying a need to improve physician and nurse communication with patients. VISN leaders also changed food service processes to provide patients with fresh foods that were cooked at a medical facility kitchen rather than serving pre-cooked and re-heated food.

The Veterans Experience Officer actively tracked patient satisfaction scores and regularly reported these data to the Quality Safety & Value and Executive Leadership Councils. To improve patient satisfaction, VISN leaders developed a script for staff to follow when reviewing information with patients after an appointment; sought to better understand veteran needs, behaviors, and experiences; and improved discharge information for patients—all of which were linked to the VISN's strategic plan objectives.

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

Table 5. Survey Results on Patient Attitudes within VISN 2 (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA Average	VISN 2 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	67.0
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.5	85.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.8	87.5

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

Access to Care

A VA priority is achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans. VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[18] VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates.[19] Wait time measures based on "create date" have the advantage of not relying on the accuracy of the "preferred date" entered into the scheduling system. These measures are particularly applicable for new primary care patients where the care is not initiated by referral or consultation that includes a "clinically indicated date."[20] The disadvantage to "create date" metrics is that wait times do not account for

[18] VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. The "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

[19] "Completed appointments cube data definitions," VA Business Intelligence Office, accessed March 28, 2019.

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

specific patient requests or availability.[21] Wait time measures based on patient preferred dates consider patient preferences but rely on appointment schedulers accurately recording the patients' wishes into the scheduling software.[22]

When patients could not be offered appointments within 30 days of their clinically indicated or preferred dates, they became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[23] However, with the passage of the VA MISSION Act of 2018 and its enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[24]

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

To examine access to primary and mental health care within VISN 2, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 6 and 7 provide wait time statistics for completed primary care and mental health appointments from January 1 through March 31, 2021.[25]

[21] Office of Veterans Access to Care, *Specialty Care Roadmap*.

[22] Office of Veterans Access to Care, *Specialty Care Roadmap*.

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

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

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

Table 6. Primary Care Appointment Wait Times (January 1 through March 31, 2021)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VISN 2	3,523	12.9
VA Finger Lakes HCS (Bath, NY)	337	15.6
James J. Peters VAMC (Bronx, NY)	681	6.3
Northport VAMC (NY)	261	19.3
Samuel S. Stratton VAMC (Albany, NY)	239	25.5
Syracuse VAMC (NY)	189	12.9
VA Hudson Valley HCS (Montrose, NY)	419	14.3
VA New Jersey HCS (East Orange)	791	10.6
VA NY Harbor HCS (NY)	392	8.4
VA Western New York HCS (Buffalo)	214	11.0

Source: VHA Support Service Center (accessed May 27, 2021).

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

Table 7. Mental Health Appointment Wait Times (January 1 through March 31, 2021)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VISN 2	747	10.2
VA Finger Lakes HCS (Bath, NY)	14	10.9
James J. Peters VAMC (Bronx, NY)	98	9.9
Northport VAMC (NY)	54	5.4
Samuel S. Stratton VAMC (Albany, NY)	78	11.6
Syracuse VAMC (NY)	64	18.1
VA Hudson Valley HCS (Montrose, NY)	34	4.4
VA New Jersey HCS (East Orange)	190	7.6
VA NY Harbor HCS (NY)	193	12.0
VA Western New York HCS (Buffalo)	22	8.2

Source: VHA Support Service Center (accessed May 27, 2021).

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

Based on wait times alone, the MISSION Act may improve access to primary care for patients in the Samuel S. Stratton and Northport VAMCs, where the average wait times for new appointments were 25.5 and 19.3 days, respectively. The wait times also highlight opportunities for these facilities to improve the timeliness of primary care provided "in house" and decrease the potential for fragmented care among patients referred to community providers.

Mental health wait times for new patients in the VISN were within parameters set by the MISSION Act. The VISN's average wait time was 10.2 days, and the longest wait time was 18.1 days at the Syracuse VAMC.

According to VISN leaders, the implementation of the MISSION Act has had a greater effect on primary care wait times in rural areas. Leaders also explained that overall wait times may have been negatively influenced by the COVID-19 pandemic. VISN leaders reported that delays at the Samuel S. Stratton VAMC were likely related to several factors, such as the loss of primary care staff and the Ambulatory Care Chief, the large catchment area, lingering effects of the COVID-19 pandemic on provider availability, and the transition of outpatient staff to provide inpatient care.

VISN leaders tracked and reported wait times for each medical facility to the Quality Safety & Value Council monthly. Leaders also implemented the "Practitioners on the Move" program in which providers (podiatrists, surgeons, and optometrists) from larger medical centers held clinics a few days a month at smaller medical centers and community-based outpatient clinics to provide specialty care examinations, treatments, and surgical referrals to the larger medical centers.

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover—or instability—and high clinical vacancy rates negatively affect access to care, quality, patient safety, and patient and staff satisfaction. Turnover can reduce employee and organizational performance through the loss of experienced staff.[26]

To assess the extent of clinical vacancies across VISN 2 facilities, the OIG held discussions with the HRO and reviewed the total number of vacancies by facility, position, service or section, and full-time equivalent (FTE) employees. Table 8 provides the vacancy rates across the VISN as of July 12, 2021.

[26] James Buchanan, "Reviewing the Benefits of Health Workforce Stability," *Human Resources for Health* 8, no. 29 (December 2010), https://doi.org/10.1186/1478-4491-8-29.

Table 8. Reported Vacancy Rates for VISN 2 Facilities (as of July 12, 2021)

Facility	Clinical Vacancies	Clinical Vacancy Rate (%)	Total Vacancy Rate (%)
VISN 2	809.1	10.6	12.4
VA Finger Lakes HCS (Bath, NY)	83.9	12.6	14.4
James J. Peters VAMC (Bronx, NY)	87.0	11.1	14.0
Northport VAMC (NY)	70.0	9.5	17.1
Samuel S. Stratton VAMC (Albany, NY)	63.9	10.4	12.5
Syracuse VAMC (NY)	106.8	11.8	13.3
VA Hudson Valley HCS (Montrose, NY)	45.1	9.9	10.9
VA New Jersey HCS (East Orange)	156.4	11.7	14.3
VA NY Harbor HCS (NY)	115.6	9.0	12.1
VA Western New York HCS (Buffalo)	80.6	9.0	12.3

Source: VISN 2: Healthcare Human Resources Officer (received July 12, 2021).

The OIG found the following FTE primary care clinical vacancies across VISN 2:

- Physicians: 24
- Physician assistants: 3
- Nurse practitioners: 13
- Nurses: 38

Clinical staffing may contribute to wait time challenges at the Samuel S. Stratton VAMC, where 1.6 physician, 2 nurse practitioner, and 7 nurse FTE positions were vacant.

For mental health, the OIG found the following FTE clinical vacancies across VISN 2:

- Psychiatrists: 27
- Psychologists: 42
- Nurses: 11
- Social workers: 53

As previously mentioned, the longest wait times were at the Syracuse VAMC, at 18.1 days; clinical staffing may contribute to these longer wait times because 3.25 psychiatrist, 6.9 psychologist, and 5 social worker FTE positions were vacant and the overall clinical vacancy rate for mental health was 17.92 percent.

Leaders reported staff recruitment challenges in rural "Upstate" areas of the VISN. To improve access in rural areas, VISN leaders staffed a Clinical Resource Hub, located at the Manhattan campus of the NY Harbor HCS, with licensed independent practitioners who provide patients with virtual care through VA Video Connect.[27] Leaders also optimized virtual healthcare delivery for the VISN Clinical Call Center in January 2021 by implementing nurse triage units, hiring licensed independent practitioners, and planning to add scheduling and pharmacy units by the end of January 2022.

The HRO discussed reporting vacancy and recruitment data to executive leaders and that hiring challenges included the rural nature of "Upstate" areas and strong salary competition in "Downstate" metropolitan areas. VISN leaders used incentives like locality pay adjustments, the Education Debt Reduction Program, and hiring bonuses to recruit qualified staff.[28] Leaders had spent $10,516,865 on recruitment, relocation, and retention bonuses and allocated $2,855,141 for the Education Debt Reduction Program in FY 2021, through the date of the OIG's visit. During the COVID-19 pandemic, leaders used VA's rapid hiring processes and increased facility staffing levels by 2,076.6 FTE employees since March 2020. As of July 12, 2021, the VISN had 17,848.8 FTE employees.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. Up to the time of the virtual inspection, the OIG had conducted 18 inspections of the VISN 2 facilities and noted that VISN and facility leaders had completed action plans for all but seven recommendations for improvement listed in appendix D.

Veterans Health Administration Performance Data

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

[27] "VA Mobile: Veterans VA Video Connect," accessed August 17, 2021, https://www.mobile.va.gov/app/va-video-connect. VA Video Connect allows veterans to see and talk with their healthcare team from anywhere. It uses encryption to ensure a secure and private session. This technology makes VA health care more convenient and reduces travel times for veterans, especially those in very rural areas with limited access to VA healthcare facilities. It also allows quick and easy healthcare access from any mobile or web-based device.

[28] "Hiring Programs and Incentives," Department of Veterans Affairs, accessed January 5, 2022, https://www.vacareers.va.gov/Benefits/HiringProgramsInitiatives/. The "Education Debt Reduction Program (EDRP) authorizes VA to provide student loan reduction payments to employees with qualifying loans who are in positions providing direct patient care and that are considered hard to recruit or retain." Each VHA facility determines which positions will qualify for the Education Debt Reduction Program.

efficiency."[29] 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.[30]

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of December 31, 2020. The figure uses blue and green data points to indicate high performance (for example, patient-centered medical home (PCMH) survey access, rating (of) PCMH provider, and mental health (MH) experience (exp) of care). Metrics that need improvement are in orange and red (for example, emergency department (ED) throughput, acute care 30-day standardized mortality ratio (SMR30), and care transition (HCAHPS)).[31]

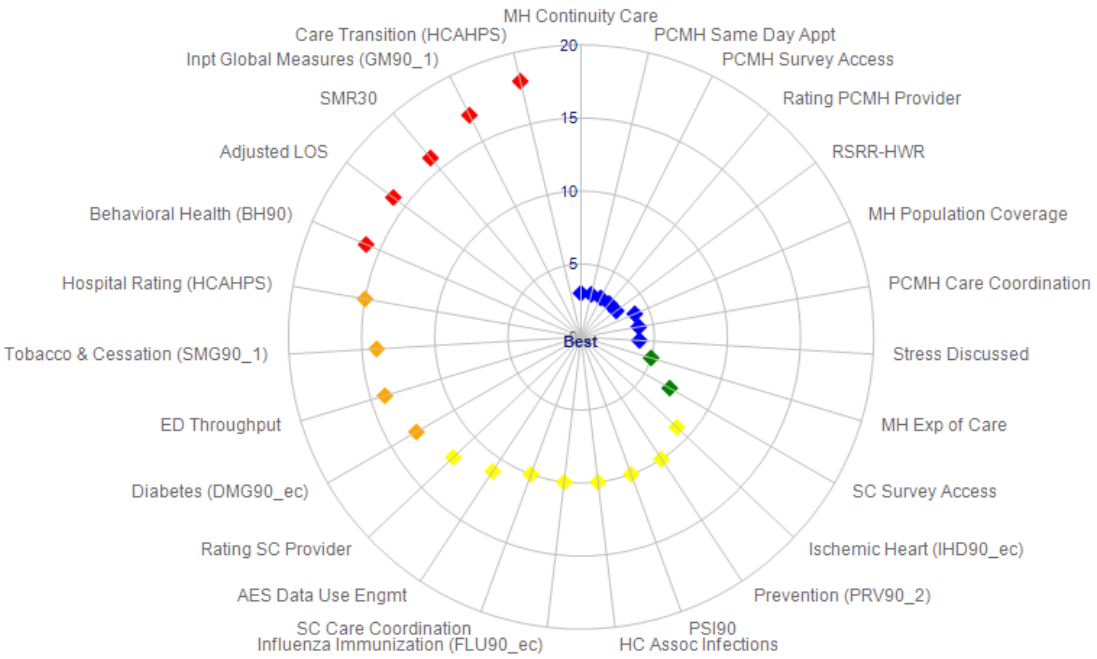

Figure 4. *VISN 2 quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 2020).*

Source: VHA Support Service Center.

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

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

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

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

VISN leaders were able to speak in depth about fifth quintile measures. They discussed monitoring performance measures at Executive Leadership Council and other healthcare committee meetings, where facility managers reported at least quarterly on the progress of improvement actions. VISN leaders also monitored performance using SAIL dashboards, which displayed metrics like mortality rates, length of stay, and mental health measures.

Prior to the COVID-19 pandemic, the VISN's strategic plan included case management improvement efforts to address care coordination and length of stay; however, once the pandemic began, leaders shifted focus, assets, and resources to infectious disease prevention. The pandemic significantly affected care transition from the VISN 2 hospitals to community nursing homes because of reluctance to accept the transfers. In response, leaders reviewed VISN-wide data and practices for the care and case management of COVID-19-positive patients and implemented improvement actions that included staff following up with patients via telephone, video, or in-person after discharge from emergency departments.

To improve standardized mortality rates for the VA New Jersey HCS and the James J. Peters and Northport VAMCs, VISN and facility leaders analyzed surgical data and implemented the following action plans:

- Increased preoperative cardiology consults for patients with anesthesia risk factors
- Preoperative review of major surgical cases by the Surgery Board
- Increased surgical intensive care postoperative testing
- Post-discharge follow-up with multiple services within 72 hours to ensure all necessary services are available

In June 2021, the VISN Systems Redesign Manager presented the Quality Safety & Value Council with a plan to improve inpatient global measures by enhancing staff's documentation and care for patients with high blood pressure, those with diabetes, and those who received pneumococcal vaccinations.

The SAIL Value Model also includes a community living center (CLC) model, which is a tool to "summarize and compare performance of CLCs in the VA."[32] The model "leverages much of the

[32] 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.

same data" used in the Centers for Medicare & Medicaid Services' *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[33]

Figure 5 illustrates the VISN's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. The figure uses blue and green data points to indicate high performance (for example, moderate-severe pain—short-stay (SS), new or worse pressure ulcer (PU) (SS), and improvement in function (SS)). Measures that need improvement are in orange and red (for example, outpatient ED visit (SS), discharged to community (SS), and physical restraints—long-stay (LS)).[34]

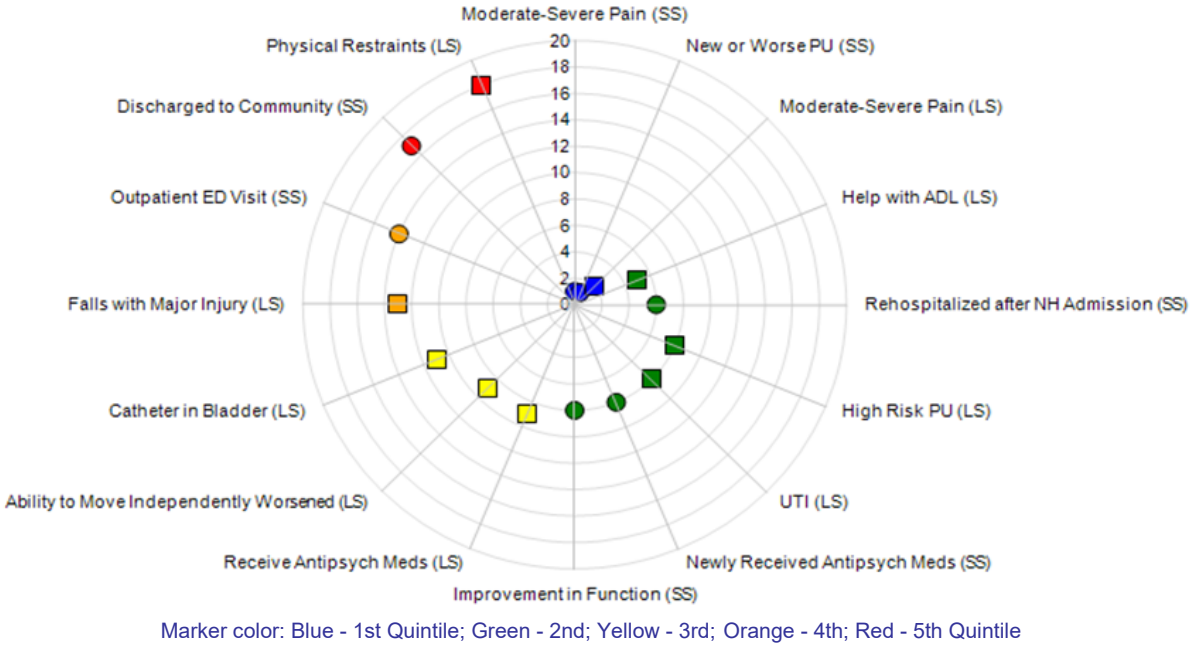

***Figure 5**. VISN 2 CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).*
LS = Long-Stay Measure. *SS = Short-Stay Measure.*
Source: VHA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.

VISN leaders reported being aware of the fourth and fifth quintile quality measures and had established a CLC Quality Assurance Committee to review performance measures and facility action plans. The committee's review of the VA Western New York HCS (Batavia) CLC quality

[33] 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."

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

scores revealed issues with staff documentation regarding restraint use and their identification of urinary tract infection symptoms. The CMO explained that the facility's CLC Resident Assessment Coordinator's departure contributed to the score because of the resulting lack of supervision and oversight. VISN staff reportedly conducted virtual inspections and mock unannounced surveys at CLCs in an attempt to improve care quality and performance.

Observed Trends in Noncompliance

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

During virtual CHIP visits of the VISN 2 facilities performed during the weeks of June 7, 22, and 28, and July 12, 2021, the OIG noted trends in noncompliance for the following areas:

- QSV
  - Surgical work group attendance
- Care coordination (inter-facility transfers)
  - Transfer monitoring and evaluation
  - Transfer note completion
  - Communication between nurses at sending and receiving facilities
- High-risk processes (management of disruptive and violent behavior)
  - Committee meeting attendance
  - Staff training

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

Leadership and Organizational Risks Conclusion

The VISN's executive leadership team was stable at the time of the OIG visit, with all members working together for almost two years. Selected survey scores related to employees' satisfaction with the VISN executive team leaders were mixed. The Network Director, Deputy Network Director, and CMO's scores were consistently higher than the VHA and VISN averages, while the QMO and HRO had opportunities to improve employee perceptions of servant leadership, psychological safety, respect, and discrimination, and reduce feelings of moral distress. The OIG noted that aggregate VISN primary and specialty care patient experience survey scores were slightly higher than VHA averages, while inpatient satisfaction scores were lower. VISN leaders appeared actively engaged with employees and patients and were working to sustain further engagement and satisfaction.

The executive team leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes by monitoring performance measures via SAIL dashboards, creating plans to enhance case management and surgical care, developing strategies to improve inpatient global measures, and conducting unannounced surveys at CLCs.

The OIG's review of access metrics and clinical vacancies identified potential organizational risks at the Samuel S. Stratton and Northport VAMCs, where there were extended average wait times and clinical vacancies in certain specialties. Leaders were knowledgeable within their scopes of responsibility about selected SAIL and CLC metrics and should continue to take actions to sustain and improve performance.

Further, the OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, care coordination, and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[35] 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.[36]

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."[37] "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."[38]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's effect on VISN 2 and its leaders' subsequent response. The OIG analyzed performance in the following domains:

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

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 2 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[39]

---

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

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

[37] 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies…During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[38] 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.

[39] 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.[40] 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.[41] Designated leaders are directly accountable for program integration and communication within their level of responsibility. Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[42]

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

- Designation of a systems redesign and improvement program manager[43]
- Establishment of a systems redesign and improvement advisory group that has representation from each VISN medical facility[44]
- Assignment of a chief surgical consultant who also serves as chairperson of the VISN surgical work group[45]
- Designation of a VISN lead surgical nurse who participates in the VISN surgical work group[46]
    - Chairperson of conference calls with VA facility surgical quality nurses
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[47]

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

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

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

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

[44] VHA Directive 1026.01.

[45] VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

[46] VHA Directive 1102.01(2).

[47] 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.

  - Monitoring of facility outlier data and communication of follow-up actions to VISN and facility directors
  - Submission of quarterly VISN peer review data analysis reports to the Office of Quality, Safety, and Value
- Quarterly reporting of institutional disclosures to the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value[48]

Quality, Safety, and Value Findings and Recommendations

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

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

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[49] When certain actions are taken against a provider's license, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the physician meets licensure requirements for VA employment.[50] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO.[51] The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with VHA policy," which includes VISN CMO oversight of facilities' processes.[52]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[53] When reports from the National Practitioner Data Bank or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

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

[49] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This handbook was in place at the time of the inspection. The credentialing section of this handbook was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers,* September 15, 2021.)

[50] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (This directive was in place at the time of the inspection. VHA Directive 2012-030 was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers,* September 15, 2021.)

[51] VHA Handbook 1100.19.

[52] VHA Handbook 1100.19.

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

Medical Staff Credentialing Finding and Recommendation

The OIG identified weaknesses in the review and approval of physicians who had potentially disqualifying licensure actions prior to their VA appointment.

VHA policy states that physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review."[54] The physicians' "credentials file[s] must be reviewed with Regional Counsel, or designee, [and]…the review and the rationale for the conclusions must be forwarded to the VISN CMO for concurrence and approval of the appointment."[55]

The OIG reviewed profile information for 448 physicians using publicly available data and VetPro and did not find evidence that the VISN CMO approved the VA appointment for a physician who was hired in February 2020 but had a license placed on probation from March 1987 to October 1988.[56] Failure to conduct the required review could result in inappropriate hiring decisions that jeopardize the quality of patient care. The CMO reported being unaware of the case.

Recommendation 1

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

VISN concurred.

Target date for completion: December 30, 2022

VISN response: The reasons for non-compliance were considered when developing the action plan. The VISN 2 VAMCs will be required to submit names of all newly hired Providers to the VISN 2 Credentialing & Privileging Officer (CPO) monthly beginning June 2022. The CPO will review the Federation of State Medical Boards (FSMB) report monthly to capture any potentially disqualifying licensure action. The VISN CPO will notify the Chief Medical Officer of any Provider(s) with a potentially disqualifying licensure action for immediate and appropriate follow-up action. This information will be reported to the VISN Quality, Safety and Value (QSV) Council on a quarterly basis beginning August 2022. The VISN QSV is chaired by the Network Director.

[54] VHA Handbook 1100.19.

[55] VHA Handbook 1100.19.

[56] VHA Handbook 1100.19. "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file."

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that healthcare facilities provide a safe, clean, and functional environment of care for veterans, their families, visitors, and employees in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[57] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[58] VHA provides policy, mandatory procedures, and operational requirements for implementing an effective supply chain management program at VA healthcare facilities which includes responsibility for VISN-level oversight.[59]

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

- Establishment of a policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee[60]
    - Met at least quarterly
    - Documented an annual review within the previous 12 months of the VISN's
        - Emergency Operations Plan
        - Continuity of Operations Plan
        - Hazards Vulnerability Analysis
    - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval

[57] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016 (This directive was in place at the time of the inspection. It was rescinded and replaced by VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.) VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[58] VHA Directive 1608. (VHA removed the requirement for VISNs to have a written policy in the updated directive.)

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

[60] VHA Directive 0320.01.

- Assessment of inventory management programs through an annual quality control review[61]

Environment of Care Findings and Recommendations

The VISN complied with most of the requirements listed above. However, the OIG identified weaknesses with Emergency Management Committee processes.

Prior to June 21, 2021, VHA required each VISN to have "a written policy that establishes and maintains a CEOC [comprehensive environment of care] Program at the VISN level."[62] The OIG did not find evidence of a VISN-level comprehensive environment of care policy. The lack of a written policy could have hindered compliance with VHA requirements and thorough oversight of facility environment of care programs. The Deputy Network Director reported being unsure why the VISN did not have a comprehensive policy. On June 21, 2021, VHA updated its comprehensive environment of care directive and removed the requirement for VISNs to have a written policy; therefore, the OIG did not issue a recommendation.[63]

VHA requires the VISN Emergency Management Committee to conduct "an annual review of the VISN Office EOP [Emergency Operations Plan], Continuity of Operations Plan (COOP), and Hazards Vulnerability Analysis (HVA)" and "VISN-wide strengths, weaknesses, priorities, and requirements for improvement that is documented in writing and sent to VISN leadership for review and approval."[64] The inspection team received the 2019 Emergency Operations Plan; Continuity of Operations Plan; Hazards Vulnerability Analysis; and VISN-wide strengths, weaknesses, priorities, and requirements for improvement. The OIG did not find evidence that the committee conducted these reviews during FY 2020. Failure to conduct the annual reviews and communicate the results to VISN leaders could prevent oversight of emergency management readiness. The Deputy Network Director and Emergency Manager reported that the committee did not conduct the annual reviews for FY 2020 because the COVID-19 pandemic caused changes in priorities and resource allocation.

[61] VHA Directive 1761(2).

[62] VHA Directive 1608.

[63] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.

[64] VHA Directive 0320.01.

Recommendation 2

2. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that the Emergency Management Committee conducts annual reviews of the Emergency and Continuity of Operations Plans; Hazards Vulnerability Analysis; and Veterans Integrated Service Network-wide strengths, weaknesses, priorities, and requirements for improvement, and submits the reviews to executive leaders for approval.

VISN concurred.

Target date for completion: November 30, 2022

VISN response: The reasons for non-compliance were considered when developing the action plan. The VISN Emergency Manager will provide the VISN Deputy Network Director a narrative report of the VISN 2 Emergency Management Program by COB October 15th each year. The Deputy Network Director will have until October 31st to review the report and provide comments. Once the report is reviewed by the Deputy Network Director, the VISN Emergency Manager will update the report as needed and submit the review to the Healthcare Operations Council by November 30th of each year. The annual report will consist of a narrative review of the following: An analysis [of] the VISN Emergency Operations Plan and Continuity of Operations Plan which contains the VISN Office Hazards Vulnerability Analysis, strengths, weaknesses, priorities, and requirements for improvement.

This information will be reported to the VISN Quality, Safety and Value (QSV) Council Annually. The VISN QSV is chaired by the Network Director.

Mental Health: Suicide Prevention

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[65] 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.[66] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[67]

VHA requires VISN leaders to appoint mental health staff to serve as a member of their primary governing body, participate on each state's suicide prevention council or workgroup, and coordinate activities with state and local mental health systems and community providers.[68]

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

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

Mental Health Findings and Recommendations

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

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

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

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

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

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 their needs can be better managed at another facility.[69]

When VA or non-VA staff transfer a patient "to a VA facility in a manner that violates [VA] policy," the VISN CMO is responsible for contacting the transferring facility and conducting a fact-finding review to determine if the transfer was appropriate.[70] Examples of patient transfers that do not comply with VA policy include

- patients who were not appropriately screened and/or did not consent prior to transfer,
- patients who were not transferred with qualified personnel or equipment,
- transfers that were not approved by a VA physician, or
- pertinent medical records were not sent with patients at the time of transfer.[71]

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

Care Coordination Findings and Recommendations

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

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

Women's Health: Comprehensive Care

Women were estimated to represent approximately 10 percent of the veteran population as of September 30, 2019.[72] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans is anticipated to increase.[73] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[74]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in all VA medical facilities.[75] VHA also requires that VISNs appoint a lead women veterans program manager (WVPM) to serve as the VISN representative on women veterans' issues and identify gaps through "VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN."[76]

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

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

[72] "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.

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

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

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

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

- Assessments to identify staff education gaps
  - Educational program and/or resources developed when needs are identified
- Availability of VISN-level support staff for implementing performance improvement projects
- Analysis of women veterans' access and satisfaction data
  - Improvement actions implemented when recommended

Women's Health Findings and Recommendations

The VISN complied with most of the requirements listed above. However, the OIG identified weaknesses with the appointment of a lead WVPM and completion of annual site visits.

VHA requires each VISN director to appoint a lead WVPM and that "a facility WVPM cannot be both the facility WVPM and VISN Lead WVPM at the same time."[77] The OIG found that the VISN did not have a permanent lead WVPM, and therefore, the WVPM from NY Harbor HCS's Manhattan campus had also covered VISN-level responsibilities since August 2019. Dual VISN and facility assignments could prevent the program manager from fully satisfying oversight responsibilities.

The acting Lead WVPM reported communicating the dual assignment to the Healthcare Delivery Council and CMO in 2020 and 2021. The CMO reported that VISN leaders posted the lead WVPM position a few times but did not get an appropriate candidate. The CMO also stated that hiring plans were derailed because of the COVID-19 pandemic, which caused a shift in priorities.

Recommendation 3

3. The Network Director evaluates and determines any additional reasons for noncompliance and appoints a permanent Veterans Integrated Service Network lead women veterans program manager.

[77] VHA Directive 1330.02.

VISN concurred.

Target date for completion: December 30, 2022

VISN response: The reasons for non-compliance were considered when developing the action plan. The vacancy for the VISN Women Veterans Program Manager (WVPM) has been posted twice as an open continuous announcement (OCA) on these dates: July 2021 through October 2021 and October 2021 through March 2022. The position is open to both Physicians and Nurse Practitioners.

To date, three separate rounds of interviews have been held from the OCA postings. The VISN has been unable to identify an appropriate candidate from the interviews held. Additionally, some candidates scheduled for second level interviews voluntarily withdrew from the recruitment process.

The VISN will continue with the recruitment process through the successful selection of the best qualified candidate for the VISN WVPM position. To ensure this, a fourth round of interviews from the OCA posting that closed on March 2022 is in the process of being scheduled.

VHA requires a lead WVPM to conduct "yearly site visits at each facility within the VISN and additional site visits as needed."[78] The OIG did not find evidence that the acting Lead WVPM conducted annual site visits at any of the VISN 2 facilities during FY 2019 or 2020. Failure to conduct yearly site visits could hinder the identification of facility concerns that warrant VISN-level intervention. The acting Lead WVPM was unable to provide a reason for not completing site visits during FY 2019 but reported not conducting in-person or virtual visits in FY 2020 because of VHA's guidance for restricted travel during the COVID-19 pandemic and dual assignment responsibilities.

Recommendation 4

4. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that a lead women veterans program manager conducts yearly visits at each facility in the Veterans Integrated Service Network.

[78] VHA Directive 1330.02.

VISN concurred.

Target date for completion: December 30, 2022

VISN response: The reasons for non-compliance were considered when developing the action plan. The VISN Chief Medical Officer will appoint two delegated staff members to conduct the required yearly visit at each facility in VISN 2. The visits will be completed by December 30, 2022.

Facility Women Veterans Program Managers are rotating monthly to ensure critical information are shared and action items are resolved timely. The VISN Women's Health Medical Director continues to provide quarterly updates on VISN 2 Women Health programs to the Healthcare Delivery Council; and serves as medical consultant to each facility in VISN 2.

The annual review report will be submitted to the VISN Quality, Safety and Value (QSV) Council by December 30, 2022. The VISN QSV is chaired by the Network Director.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Healthcare Processes	Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinical vacancies • Oversight inspections • VHA performance data • Observed trends in noncompliance	Four OIG recommendations aimed at reducing vulnerabilities that can lead to patient and staff safety issues or adverse events are attributable to the Network Director and Chief Medical Officer. See details below.
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback • Vaccine Administration	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 2 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

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

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

Appendix B: VISN 2 Profile

The table below provides general background information for VISN 2.

Table B.1. Profile for VISN 2
(October 1, 2017, through September 30, 2020)

Profile Element	VISN Data FY 2018*	VISN Data FY 2019†	VISN Data FY 2020‡
Total medical care budget	$3,603,710,261	$3,598,230,838	$3,997,310,611
Number of:			
• Unique patients	303,448	300,322	288,842
• Outpatient visits	4,498,986	4,533,661	3,996,014
• Unique employees§	20,845	21,046	20,861
Type and number of operating beds:			
• Community living center	1,445	1,445	1,437
• Domiciliary	708	648	610
• Hospital	1,330	1,052	1,052
Average daily census:			
• Community living center	789	929	846
• Domiciliary	531	539	338
• Hospital	520	530	492

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

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

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

Appendix C: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 2 (October 1, 2019, through September 30, 2020)

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	VHA	69.5
		VISN 2	67.0
		Albany, NY	65.8
		Bronx, NY	60.4
		Buffalo, NY	73.7
		East Orange, NJ	56.4
		Finger Lakes, NY	64.3
		Montrose, NY	61.3
		New York, NY	62.9
		Northport, NY	67.6
		Syracuse, NY	75.2
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	82.5
		VISN 2	85.7
		Albany, NY	86.0
		Bronx, NY	79.9
		Buffalo, NY	85.4
		East Orange, NJ	85.3
		Finger Lakes, NY	86.2
		Montrose, NY	87.8
		New York, NY	83.7
		Northport, NY	87.4
		Syracuse, NY	88.2

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.8
		VISN 2	87.5
		Albany, NY	87.7
		Bronx, NY	87.2
		Buffalo, NY	85.2
		East Orange, NJ	83.0
		Finger Lakes, NY	88.4
		Montrose, NY	90.9
		New York, NY	88.6
		Northport, NY	89.1
		Syracuse, NY	90.3

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

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns at the Samuel S. Stratton VA Medical Center, Albany, New York, Report No. 17-01770-188, August 29, 2018	February, April, and June 2017	1	8	0	0
Clinical Assessment Program Review of the Syracuse VA Medical Center, Syracuse, New York, Report No. 16-00558-311, August 7, 2017	March 2017	0	13	–	0
Comprehensive Healthcare Inspection Program Review of the James J. Peters VA Medical Center, Bronx, New York, Report No. 17-01751-25, November 29, 2017	April 2017	0	15	–	0
Comprehensive Healthcare Inspection Program Review of the Bath VA Medical Center, Bath, New York, Report No. 17-01752-32, December 7, 2017	May 2017	0	11	–	0
Comprehensive Healthcare Inspection Program Review of the VA New York Harbor Healthcare System, New York, New York, Report No. 17-01762-88, February 7, 2018	June 2017	0	14	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center, New York, Report No. 17-01823-287, September 12, 2018*	–	1	5	0	0
Alleged Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York, Report No. 17-03347-290, September 18, 2018	June and August 2017	1	8	0	0
Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center, New York, Report No. 17-03347-285, September 18, 2018	October 2017	0	3	–	0
Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York, Report No. 17-03347-293, September 18, 2018	October 2017	0	3	–	0
Comprehensive Healthcare Inspection Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York, Report No. 17-05407-141, March 29, 2018	October 2017	0	10	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection Program Review of the VA Hudson Valley Health Care System, Montrose, New York, Report No. 17-05399-194, June 26, 2018	October 2017	0	6	–	0
Comprehensive Healthcare Inspection Program Review of the Northport VA Medical Center, New York, Report No. 18-01018-281, September 18, 2018	April 2018	0	11	–	0
Comprehensive Healthcare Inspection Program Review of the VA New Jersey Health Care System, East Orange, New Jersey, Report No. 18-01164-42, December 27, 2018	August 2018	0	6	–	0
Comprehensive Healthcare Inspection of the VA Western New York Healthcare System, *Buffalo, New York*, Report No. 18-04666-55, January 7, 2020	March 2019	0	18	–	0
A Delay in Patient Notification of Test Results and Other Communication Issues at the Bath VA Medical Center, *New York*, Report No. 19-07070-75, January 21, 2020	April 2019	0	2	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection of the Canandaigua VA Medical Center, New York, Report No. 19-00037-58, January 9, 2020	May 2019	0	14	–	0
VHA's Response following Cardiac Catheterization Lab Closure at the Samuel S. Stratton VA Medical Center in Albany, New York, Report No. 19-09129-76, February 17, 2021†	–	2	0	0	–
Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens, Report No. 20-02968-170, June 22, 2021	–	0	7	–	7‡

Source: Inspection/survey results verified with the Executive Assistant/Health System Specialist on July 15, 2021.

***** *This report also includes one recommendation under the purview of the VHA Under Secretary for Health and one recommendation attributed to the Veterans Health Administration Office of Mental Health Services, Substance Use Disorders. For the purpose of comprehensive healthcare inspections, the OIG references only those recommendations under the scope of the VISN and facilities.*

† *This report also includes one recommendation under the purview of the VHA Under Secretary for Health.*

‡ *As of May 2022, 2 of 7 recommendations remained open.*

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use engmt	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
Behavioral health (BH90)	Healthcare Effectiveness Data and Information Set (HEDIS) outpatient performance measure composite related to screening for depression, posttraumatic stress disorder, alcohol misuse, and suicide risk	A higher value is better than a lower value
Care transition (HCAHPS)	Care transition (inpatient)	A higher value is better than a lower value
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 (ED)	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
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 (FY14Q3 and later)	A higher value is better than a lower value

Measure	Definition	Desired Direction
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH population coverage	Mental health population coverage (FY14Q3 and later)	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 appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
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)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care (SC) providers	A higher value is better than a lower value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
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: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 12, 2022

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

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 2: New York/New Jersey VA Health Care Network

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

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 Veterans Integrated Service Network 2: New York/New Jersey VA Health Care Network. I concur with the report findings, recommendations and corrective action plans submitted.

(Original signed by:)

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

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	Randall Snow, JD, Team Leader Tishanna McCutchen, DNP, MSPH
Other Contributors	Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Scott McGrath, BS Amy McCarthy, JD Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Elizabeth K. Whidden, MS, APRN Yurong Tan, PhD

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

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
  New Jersey: Cory Booker, Bob Menendez
  New York: Kirsten Gillibrand, Charles Schumer
  Pennsylvania: Bob Casey, Pat Toomey
U.S. House of Representatives
  New Jersey: Josh Gottheimer; Andy Kim; Tom Malinowski; Donald Norcross; Frank Pallone, Jr.; Bill Pascrell; Donald M. Payne, Jr.; Mikie Sherrill; Albio Sires; Chris Smith; Jefferson Van Drew; Bonnie Watson Coleman
  New York: Jamaal Bowman, Yvette D. Clarke, Antonio Delgado, Adriano Espaillat, Andrew Garbarino, Brian Higgins, Chris Jacobs, Hakeem Jeffries, Mondaire Jones, John Katko, Nicole Malliotakis, Carolyn B. Maloney, Sean Patrick Maloney, Gregory Meeks, Grace Meng, Joseph Morelle, Jerry Nadler, Alexandria Ocasio-Cortez, Kathleen Rice, Elise Stefanik, Thomas Suozzi, Claudia Tenney, Paul D. Tonko, Ritchie Torres, Nydia M. Velázquez, Lee Zeldin
  Pennsylvania: Glenn "GT" Thompson, Mike Kelly

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