



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare  
Inspection of the VA Finger  
Lakes Healthcare System  
in Bath, New York



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**Figure 1.** VA Finger Lakes Healthcare System in Bath, New York.

Source: <https://www.va.gov/finger-lakes-health-care/locations/> (accessed March 23, 2022).

## Abbreviations

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



## Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Finger Lakes Healthcare System, which includes two campuses—the Bath and Canandaigua VA Medical Centers—that merged into one organization on October 1, 2018, as well as multiple outpatient clinics in New York and Pennsylvania. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

The OIG conducted an unannounced virtual inspection of the VA Finger Lakes Healthcare System during the week of June 22, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors’ ability to assess all areas of clinical risk. The findings presented in this report

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<sup>1</sup> “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](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).”

<sup>2</sup> The OIG’s review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the VA Finger Lakes Healthcare System because staff did not administer remdesivir during the review period.

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

## **Inspection Results**

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

### **Leadership and Organizational Risks**

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

When the team conducted this inspection, the healthcare system's leaders had worked together for approximately three months, since the Associate and Assistant Directors were assigned in March 2021. The Associate Director for Patient and Nursing Services had served at the Bath VA Medical Center since 2014, prior to the formation of the healthcare system in 2018, and transitioned to the current position in 2019 after it was vacated by the Associate Director for Patient and Nursing Services for the Canandaigua VA Medical Center. The Assistant Director served as the Associate Director from 2013 to 2020. In October 2020, as part of an integration and restructuring effort, the associate director position was reclassified to a higher grade level and the new Associate Director was hired in March 2021 (the prior Associate Director was assigned to the newly established assistant director position). From October 28, 2020, through March 28, 2021, the Assistant Director covered as the acting Associate Director until the position was filled.

The OIG reviewed employee satisfaction survey results and concluded that averages from selected leadership questions for the two medical centers were similar to or lower than VHA averages. The Director explained that the integration into the VA Finger Lakes Healthcare System created some challenges, which included the collection and mapping of the healthcare system data for the fiscal year 2020 All Employee Survey. The Director explained that although the healthcare system began integration in 2018, the scores for system leaders would not be fully integrated until the fiscal year 2021 All Employee Survey. Overall, patient experience survey

respondents generally appeared satisfied with the outpatient care provided but rated inpatient care lower than VHA patients nationally. Gender-specific data also showed opportunities for leaders to improve some outpatient care metrics for both male and female patients.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.<sup>3</sup> However, the OIG identified a vulnerability with the difficulty in staffing the risk manager position at the Canandaigua VA Medical Center. The Deputy Quality Chief/Risk Manager described the risk manager position as one that requires knowledge of clinical issues, legal liability, and the ability to effectively communicate with system leaders. At the time of the virtual site visit, multiple postings for the position had not yet yielded applicants with the appropriate knowledge or experience.

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.”<sup>4</sup> System leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and Community Living Center SAIL models.

## **COVID-19 Pandemic Readiness and Response**

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.<sup>5</sup>

### **Mental Health**

The healthcare system complied with requirements related to suicide prevention screening within urgent care centers. However, the OIG found that staff responsible for suicide safety plan development had not completed the required training.

### **Care Coordination**

Generally, the healthcare system complied with requirements for the completion of the VA transfer form or facility-defined equivalent. However, the OIG identified deficiencies with

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

<sup>4</sup> “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.)

<sup>5</sup> 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.

monitoring and evaluation of inter-facility transfers, transmission of medical records to the receiving facility, and communication between nurses at sending and receiving facilities.

## High-Risk Processes

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

## Conclusion

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

## VA Comments

The Veterans Integrated Service Network Director and acting System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 60–61, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendation 2 closed. 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



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## Purpose and Scope

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

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.<sup>2</sup> Effective leadership has been cited as “among the most critical components that lead an organization to effective and successful outcomes.”<sup>3</sup> Figure 2 illustrates the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

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

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

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

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<sup>1</sup> VA administers healthcare services through a network of 18 regional offices nationwide referred to as the Veterans Integrated Service Network.

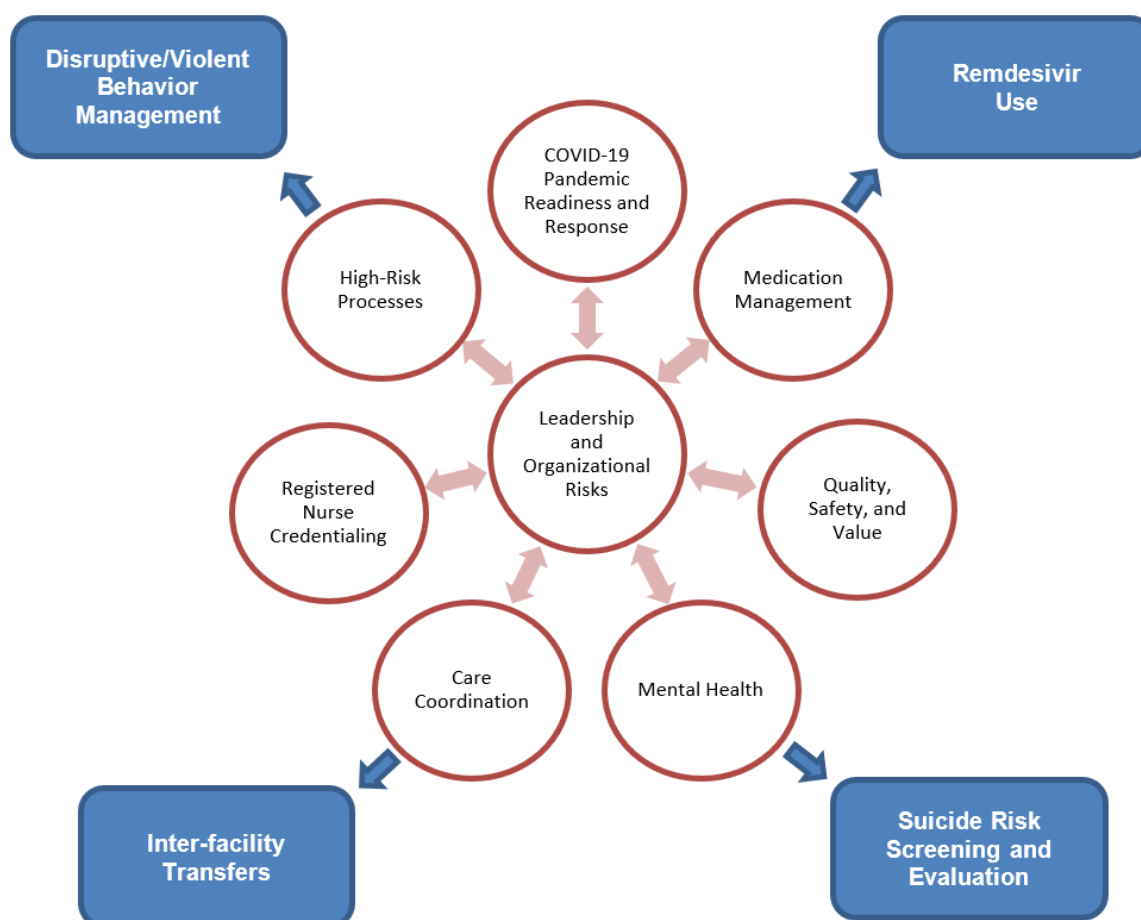
<sup>2</sup> Anam Parand et al., “The role of hospital managers in quality and patient safety: a systematic review,” *British Medical Journal*, 4, no. 9, (September 5, 2014): <https://doi.org/10.1136/bmjopen-2014-005055>.

<sup>3</sup> 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>.

<sup>4</sup> 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.

<sup>5</sup> “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](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 (coronavirus disease) is an infectious disease caused by the “severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).”

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



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

Source: VA OIG.

<sup>6</sup> The OIG’s review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the VA Finger Lakes Healthcare System because staff did not administer remdesivir during the review period.

## Methodology

The VA Finger Lakes Healthcare System includes two medical center campuses—the Bath and Canandaigua VA Medical Centers (VAMCs)—that merged into one organization on October 1, 2018, as well as multiple outpatient clinics in New York and Pennsylvania. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from May 13, 2017, the last CHIP site visit at the Bath VAMC, through June 25, 2021, the last day of the unannounced multiday evaluation.<sup>8</sup> During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.<sup>9</sup>

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.<sup>10</sup> The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

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

<sup>8</sup> The range represents the time period from the prior CHIP site visit at the Bath VAMC to the completion of the unannounced, multiday virtual CHIP visit in June 2021.

<sup>9</sup> 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.

<sup>10</sup> Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

## Results and Recommendations

### Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect a healthcare system's ability to provide care in the clinical focus areas.<sup>11</sup> To assess this healthcare system's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the healthcare system response
8. VHA performance data (healthcare system)
9. VHA performance data (community living center (CLC))<sup>12</sup>

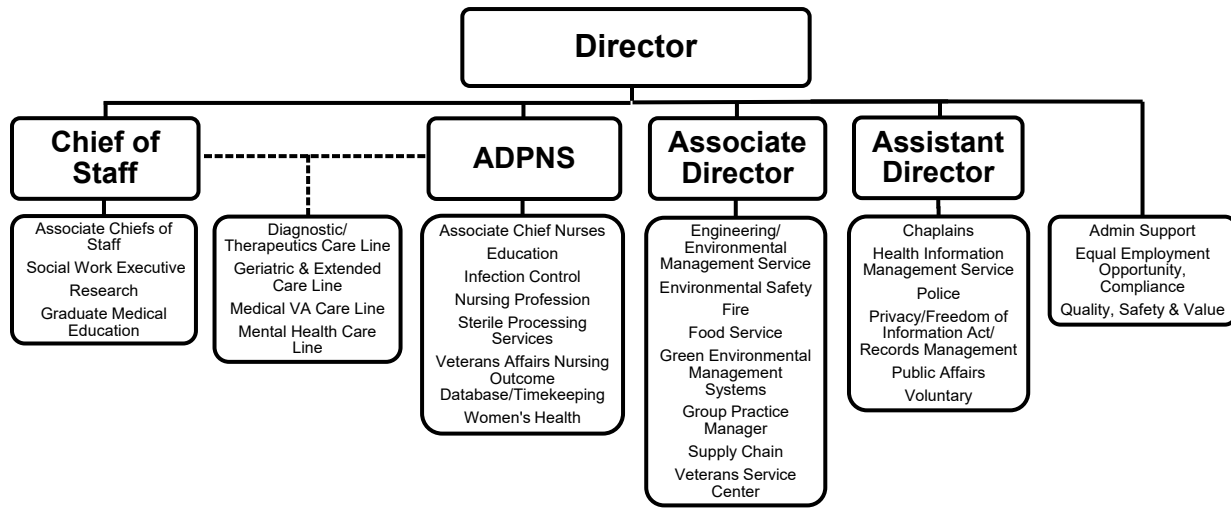
### Executive Leadership Position Stability and Engagement

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

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<sup>11</sup> Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper, 2006.

<sup>12</sup> VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. CLCs, previously known as nursing home care units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.



**Figure 3.** Healthcare system organizational chart.

Source: VA Finger Lakes Healthcare System (received June 22, 2021, updated March 8, 2022).

At the time of the OIG inspection, the executive team had worked together for approximately three months, since the Associate and Assistant Directors were assigned in March 2021. The ADPNS had served at the Bath VAMC since 2014 and remained in that role after the healthcare system was established in October 2018. In 2019, after the ADPNS for the Canandaigua VAMC vacated the position, the ADPNS at the Bath VAMC assumed the role for the entire healthcare system. The Assistant Director served as the Associate Director from 2013 to 2020. In October 2020, as part of the healthcare system’s integration and restructuring, the associate director position was reclassified to a higher grade level. In March 2021, the prior Associate Director was reassigned as the new Assistant Director but continued to serve as the acting Associate Director until that position was filled (see table 1).

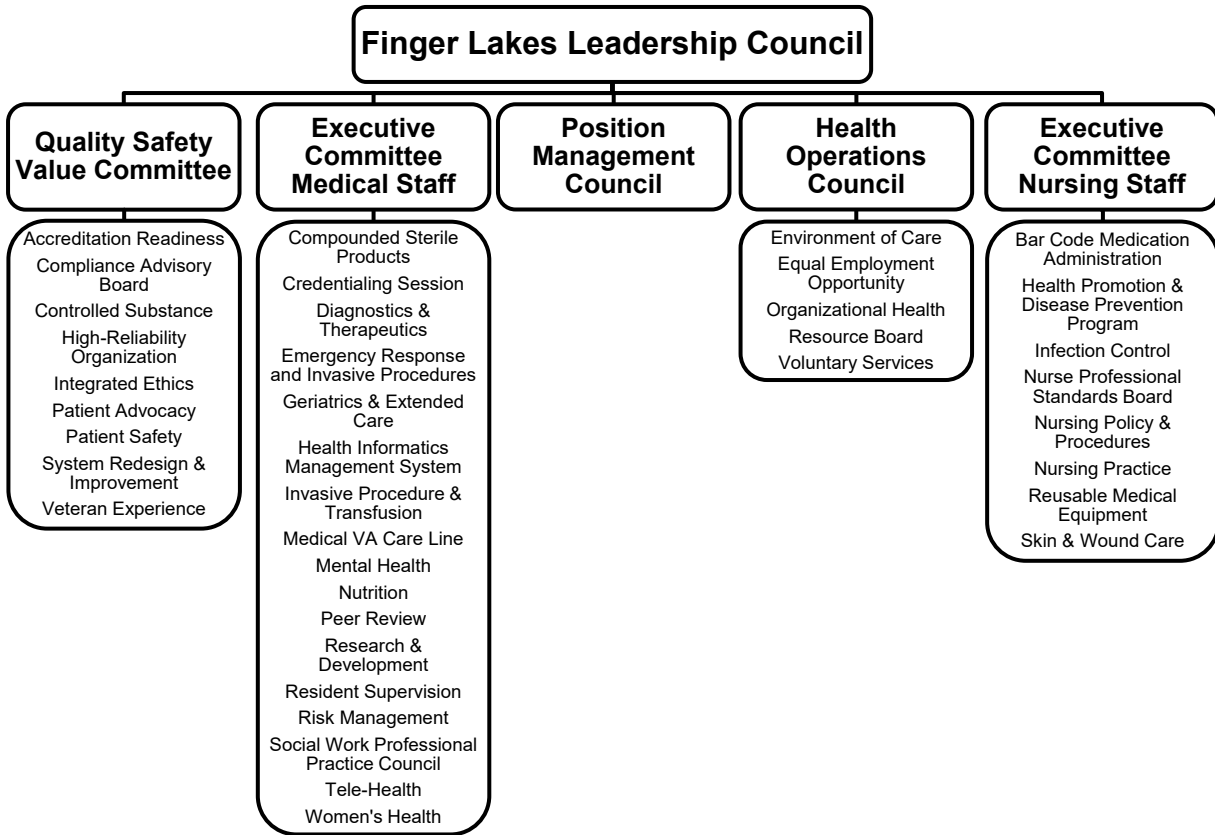
**Table 1. Executive Leader Assignments**

Leadership Position	Assignment Date
System Director	May 12, 2019
Chief of Staff	April 16, 2017
Associate Director for Patient and Nursing Services	November 2, 2014
Associate Director	March 28, 2021
Assistant Director	March 28, 2021

Source: VA Finger Lakes Healthcare System Senior Strategic Business Partner/Assistant Human Resources Officer (received June 23, 2021).

The Director served as the chairperson of the Finger Lakes Leadership Council, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Finger Lakes Leadership Council provided oversight of various committees and councils such as the Quality Safety Value

Committee, Executive Committee of the Medical Staff, and Health Operations Council. The executive leaders monitored patient safety and care through the Quality Safety Value Committee, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).



**Figure 4.** Healthcare system committee reporting structure.

Source: VA Finger Lakes Healthcare System (received June 22, 2021).

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

## Budget and Operations

The OIG noted that the annual medical care budget for the healthcare system during FY 2020 was \$324,491,936, which was an increase of 17 percent from the FY 2019 combined total of \$276,680,742 for both medical centers.<sup>13</sup> When asked about the effect of this change on the

<sup>13</sup> The FY 2019 annual medical care budgets for the Bath and Canandaigua VAMCs were \$111,398,544 and \$165,282,197, respectively.



healthcare system's operations, the Director indicated that the budget increase helped in many areas, including the purchase of medical equipment and expansion of shuttle service between the Buffalo, Syracuse, Canandaigua, and Rochester VHA locations.

## Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.<sup>14</sup> Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.<sup>15</sup> In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.<sup>16</sup>

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.<sup>17</sup> System leaders confirmed that occupational shortages listed in table 2 remained the top clinical and nonclinical shortages, except for nurse practitioners and equal employment opportunity staff. The leaders stated there were additional shortages of laboratory technologists and administrative officers. The Director discussed implementing several interim strategies to alleviate stressors associated with the current staffing shortages, such as recruitment incentives up to \$5,000; increased pay rates for nurse practitioners, RNs, and licensed practical nurses; employment of extra custodial workers; and special pay rates for engineers. The Director explained that leaders submitted a pay increase request for nursing staff to the VISN on June 16, 2021, and conducted virtual job fairs, but acknowledged that hiring nurses during the pandemic was challenging due to significantly higher salaries being offered in the private sector.

The ADPNS identified the healthcare system's rural location and the continued pandemic as barriers for hiring but reported that overall staffing for the CLC was much better than in the private sector. The ADPNS also stated that COVID-19 affected the system's ability to accept nursing students for clinical rotations, which is a primary method of recruitment, and described training outpatient staff to provide inpatient care and using contract nurses when needed.

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<sup>14</sup> Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

<sup>15</sup> VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46 (2017); VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*, Report No. 20-01249-259, September 23, 2020.

<sup>16</sup> VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018.

<sup>17</sup> VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Registered Nurse Staff–Inpatient CLC	1. General Facilities and Equipment (Biomed Equipment Support Specialist)
2. Primary Care	2. Custodial Worker
3. Psychiatry	3. General Engineering
4. Medical Technologists	4. Equal Employment Opportunity
5. Nurse Practitioners–Long Term Care	5. Motor Vehicle Operator

Source: VA OIG.

## Employee Satisfaction

The All Employee Survey “is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.”<sup>18</sup> Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health.<sup>19</sup> Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey from October 1, 2019, through September 30, 2020.<sup>20</sup> Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. The Director explained that the integration into the VA Finger Lakes Healthcare System created some challenges, which included the collection and mapping of healthcare system data for the FY 2020 All Employee Survey. The Director also explained that although the healthcare system began integration in 2018, the scores for system leaders would not be fully integrated until the FY 2021 survey.

<sup>18</sup> “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](http://aes.vssc.med.va.gov/Documents/04_AES_History_Concepts.pdf). (This is an internal website not publicly accessible.)

<sup>19</sup> “AES Survey History.”

<sup>20</sup> Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, and Associate Director. The OIG was unable to make a comparison of the ADPNS scores to other leaders because different methods were used to report and map the results at the Bath and Canandaigua VAMCs. Results from the Bath VAMC included all staff from the nursing service, while results from the Canandaigua VAMC only provided data for staff reporting directly to the ADPNS. Additionally, the 2020 All Employee Survey results are not reflective of employee satisfaction with the current Associate Director, who assumed the role after the survey was administered, and no results are available for the Assistant Director because the position was not filled at the time the survey was administered.

The OIG found that averages from the two medical centers for selected survey leadership questions were similar to or lower than the VHA average.<sup>21</sup> Scores for the Director and Chief of Staff were consistently higher than those for VHA and the two medical centers. Scores for the current Associate Director, who served in the position that was filled by the current Assistant Director at the time of the survey, were similar to or lower than VHA averages. However, the score related to employees' perception that leaders maintained high standards of honesty and integrity was higher. The survey results revealed an opportunity for system leaders to improve employee perceptions of servant leadership (a measure of supervisors' listening, respect, trust, favoritism, and response to concerns). Leaders spoke of conducting morning huddles, known as STEPS (Safety Team Equipment Process Supplies), with staff reporting directly to them prior to the daily morning meeting with healthcare system leaders. The Associate Director described the significance of the daily STEPS meetings as a way for staff to discuss issues and develop strategies for resolution.

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<sup>21</sup> The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

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

Questions/ Survey Items	Scoring	VHA Average	Bath VAMC Average	Canandaigua VAMC Average	Director Average	Chief of Staff Average	Assoc. Director Average
All Employee Survey: <i>Servant Leader Index Composite.*</i>	0–100 where higher scores are more favorable	73.8	69.4	73.7	97.8	87.8	69.7
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.3	3.3	4.8	4.2	3.4
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	3.5	4.9	4.1	3.9
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.6	3.5	4.8	4.1	3.6

Source: VA All Employee Survey (accessed May 19 and 24, 2021).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.<sup>22</sup> The averages for the two medical centers for the selected survey questions were similar to the VHA averages. Scores related to the Director and Chief of Staff were consistently better than those for VHA and the two medical centers.

<sup>22</sup> Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, and Associate Director.

The leaders described actions used to improve and maintain employee satisfaction, including ways to promote honesty, integrity, and transparency. The ADPNS expressed the importance of communicating information to both service chiefs and front line staff, and the Chief of Staff emphasized the value of open communication and respect. Additionally, the Associate and Assistant Directors identified the ongoing need to improve communication, and the Associate Director discussed conducting rounds to different services and holding monthly safety forums to improve the workplace environment. The Director described how a recent sentinel event involving the use of a wrong-sized needle was discussed at a safety meeting to exemplify the importance of promoting transparency, reporting issues, and taking actions to ensure processes are in place to prevent similar future events. System leaders reported increasing staff trust and safety by attending their meetings, conducting rounds, and following up when they had concerns. The Associate Director shared an example of staff engagement, reporting that over 77 percent of staff had completed white belt training, which is a continuous process improvement program.

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

Questions/ Survey Items	Scoring	VHA Average	Bath VAMC System Average	Canandaigua VAMC Average	Director Average	Chief of Staff Average	Assoc. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	3.7	5.0	4.6	4.1
All Employee Survey: <i>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).</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	3.6	4.6	4.4	3.9
All Employee Survey: <i>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)?</i>	0 (Never)–6 (Every Day)	1.4	1.4	1.3	0.8	1.1	1.5

Source: VA All Employee Survey (accessed May 19 and 24, 2021).

VHA leaders have articulated that the agency “is committed to a harassment-free health care environment.”<sup>23</sup> To this end, leaders initiated the “End Harassment” and “Stand Up to Stop

<sup>23</sup> “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 feel secure and respected.<sup>24</sup>

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA’s All Employee Survey responses. The averages for the two medical centers were similar to or lower than the VHA average, while system leaders’ scores were similar to or higher than VHA and the medical centers. The Director reported implementing strategies from VA’s “Stand Up to Stop Harassment Now!” campaign by discussing the topics of whistleblower protection and harassment in town halls, staff meetings, emails, and activities.<sup>25</sup> The Chief of Staff discussed the importance of leaders respecting others and maintaining open communication with staff. The Associate Director promoted the concept of staff speaking up when they are uncomfortable. The ADPNS described promoting a “Just Culture” philosophy by reviewing system problems rather than blaming employees.

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

Questions/ Survey Items	Scoring	VHA Average	Bath VAMC Average	Canandaigua VAMC Average	Director Average	Chief of Staff Average	Assoc. Director Average
All Employee Survey: <i>People treat each other with respect in my workgroup.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	3.7	3.8	4.9	4.4	4.1
All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	4.1	4.1	4.1	4.9	4.7	4.3
All Employee Survey: <i>Members in my workgroup are able to bring up problems and tough issues.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.6	3.7	4.9	4.7	3.8

Source: VA All Employee Survey (accessed May 19 and 24, 2021).

## Patient Experience

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

<sup>24</sup> “Stand Up to Stop Harassment Now!”

<sup>25</sup> Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*.

of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and support benchmarking its performance against the private sector.

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients’ attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the healthcare system.<sup>26</sup> The overall patient satisfaction survey results reflected higher care ratings than VHA averages for patient-centered medical home (primary care) and specialty care. However, the inpatient score regarding the willingness to recommend the hospital to family and friends was lower than the VHA average.

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

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	69.5	64.3*
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	82.5	86.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	84.8	88.4

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

*\*Inpatient care is only provided at the Bath VAMC.*

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

<sup>26</sup> Ratings are based on responses by patients who received care at this healthcare system.



by 2048.<sup>27</sup> For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). The inpatient survey scores regarding male patients recommending the hospital to family and friends and their perceptions of doctors and nurses treating them with courtesy and respect were lower than VHA averages (data for female patients were not available due to the small number of respondents). For patient-centered medical home care, scores for male patients were similar to or higher than VHA averages. However, female patients' scores were not as positive regarding access to routine appointments. For specialty care, male respondents' scores were similar to or higher than VHA averages and female patients' scores were consistently higher. System leaders appeared to be actively engaged with male and female patients, but results indicated opportunities for them to improve inpatient experiences for male patients and outpatient experiences for patients of both genders.

System leaders reported receiving a women's health grant on June 8, 2021, which they planned to use to hire additional staff and purchase cervical exam supplies and equipment. The Director and Associate Director discussed the expansion of both the Rochester clinic, including gastrointestinal and dental services, and the shuttle service between the healthcare system and the Buffalo, Rochester, and Syracuse VHA locations. The Director also stated that, while specialty care is limited when compared to other VA facilities, the system's small size allows providers to get to know their patients well. The Chief of Staff reported making it a priority to recruit and retain quality providers by participating in the interview process.

System leaders also discussed working to increase the availability of services for women veterans since the women's health primary care providers only worked part-time. The Chief of Staff described the implementation of a mammography van, which has reduced the need for community referrals. When asked what VHA can do to be more inviting to women veterans, the Chief of Staff explained the importance of staff recognizing that when a female is present with a male during an appointment, the female may be the veteran patient as opposed to a common misperception that the male is always the patient.

System leaders reported that the staff were invested in improving the patient experience. The ADPNS stated that a nursing assistant created a bulletin board in the CLC to educate others on urinary tract infections. The ADPNS also provided the OIG a presentation showcasing projects that improved safety and quality of care. For example, one of several strong practices shared by the ADPNS included the implementation of a telehealth urgent care process that reduced

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<sup>27</sup> "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](https://www.va.gov/vetdata/Veteran_Population.asp).

community care emergency department visits. System leaders appeared actively engaged with employees and patients and reported working to further improve and sustain engagement and satisfaction.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average‡
<i>Would you recommend this hospital to your friends and family?</i>	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	63.7	–
<i>During this hospital stay, how often did doctors treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	83.1	–
<i>During this hospital stay, how often did nurses treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	76.7	–

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

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

†The healthcare system averages are based on 72 male respondents. Inpatient care is only provided at the Bath VAMC campus.

‡Data are not available due to the small number of female respondents.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	56.3	45.2
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	64.1	47.3
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	73.9	69.5

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

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

†The healthcare system averages are based on 229–741 male and 28–56 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	49.3	57.8
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	65.0	75.0
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	80.0	94.3

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

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

†The healthcare system averages are based on 506–1,537 male and 25–80 female respondents, depending on the question.

## Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.<sup>28</sup> The Canandaigua VAMC had an OIG CHIP visit the week of May 13, 2019, and the last OIG CHIP visit to the Bath VAMC was the week of May 8, 2017.

The OIG reviewed inspection reports for both VAMCs from The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities, Long Term Care Institute, College of

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

American Pathologists, and Pathology and Laboratory Medicine Service National Enforcement accreditation since the last OIG CHIP visit to the Bath VAMC on May 8, 2017.<sup>29</sup>

Table 10 summarizes the relevant system inspections performed by the OIG and TJC.<sup>30</sup> There were no open recommendations from the two previously mentioned OIG CHIP visits or two prior focused OIG reports.<sup>31</sup> The VA Finger Lakes Healthcare System was inspected by TJC in April 2021, which resulted in 30 recommendations. Additionally, TJC conducted a laboratory inspection in May 2021, resulting in 6 recommendations. The Director and Deputy Quality Chief/Risk Manager spoke knowledgably about the progress of actions taken to improve the quality and safety of care, including implementation, monitoring of outcomes, and closure of actions from external surveys. The Deputy Quality Chief/Risk Manager stated that system staff were actively working on improvement actions.

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<sup>29</sup> VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities “provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies.” VHA’s commitment “is supported through a system-wide, long-term joint collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.” “About Us,” Long Term Care Institute, accessed December 8, 2020, <http://www.ltcior.org/about-us/>. The Long Term Care Institute is “focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings.” About the College of American Pathologists,” College of American Pathologists, accessed February 20, 2019, <https://www.cap.org/about-the-cap>. According to the College of American Pathologists, for 75 years it has “fostered excellence in laboratories and advanced the practice of pathology and laboratory science.” Additionally, as stated in VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

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

<sup>31</sup> VA OIG, *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. VA OIG, *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.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG ( <i>Comprehensive Healthcare Inspection Program Review of the Bath VA Medical Center, Bath, New York, Report No. 17-01752-32, December 7, 2017</i> )	May 2017	11	0
OIG ( <i>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</i> )	August 2017	8	0
OIG ( <i>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</i> )	April 2019	2	0
OIG ( <i>Comprehensive Healthcare Inspection of the Canandaigua VA Medical Center, New York, Report No. 19-00037-58, January 9, 2020</i> )	May 2019	14	0
TJC Hospital Accreditation	May 2018	21	0
TJC Behavioral Health Care Accreditation		10	0
TJC Home Care Accreditation (Bath VA Medical Center)		6	0
TJC Ambulatory Accreditation	May 2018	3	0
TJC Behavioral Health Care Accreditation		7	0
TJC Home Care Accreditation (Canandaigua VA Medical Center)*		4	0
TJC Hospital Accreditation	April 2021	23	23
TJC Behavioral Health Care Accreditation		2	2
TJC Home Care Accreditation (VA Finger Lakes Healthcare System)		5	5
TJC Laboratory Services (VA Finger Lakes Healthcare System)	May 2021	6	6

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

\*This TJC report was previously noted in the OIG's *Comprehensive Healthcare Inspection of the Canandaigua VA Medical Center, New York, Report No. 19-00037-58, published January 9, 2020.*

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

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be

able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

The OIG reviewed and discussed the two large-scale disclosures that had been completed since May 8, 2017, with the Director, Chief of Staff, ADPNS, and Deputy Quality Chief/Risk Manager. The Director reported that because each medical center had different procedures for reporting sentinel events, leaders implemented a new policy on June 11, 2021, to standardize the reporting process at both campuses.

The Director explained the differences between clinical and institutional disclosures and the involvement of QSV staff. The Director discussed using a collaborative decision-making process to determine the need for an institutional disclosure. The Chief of Staff described reviewing all sentinel events, meeting with the Risk Manager, and conducting clinical reviews. The Chief of Staff detailed the process for discussing sentinel events that met the criteria for institutional disclosures with veterans and family members. For large-scale disclosures, the Director reported working with the Network Director and VISN staff.

Table 11 lists the reported patient safety events from May 13, 2017 (the last OIG CHIP site visit at the Bath VAMC), to June 22, 2021.<sup>32</sup>

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<sup>32</sup> It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The VA Finger Lakes Healthcare System is a low complexity (3) affiliated system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.” Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.” Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.”

**Table 11. Summary of Selected Organizational Risk Factors (May 13, 2017, to June 22, 2021)**

Factor	Number of Occurrences
Sentinel Events	1
Institutional Disclosures	3*
Large-Scale Disclosures	2

*Source: VA Finger Lakes Healthcare System’s Deputy Quality Chief/Risk Manager and Patient Safety Manager (received June 22, 2021).*

*\*Two institutional disclosures were from the Bath VAMC since the last OIG CHIP site visit in May 2017, and one was previously reported in the Canandaigua VAMC 2019 OIG CHIP report.*

The OIG’s review of the system’s accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG identified an area of vulnerability related to difficulty staffing the risk manager position at the Canandaigua VAMC. The Director reported that this position is currently filled with an intermittent risk manager. At the Bath VAMC, the Deputy Quality Chief served in a dual role as the Risk Manager, and since December 2020, also served as the acting Credentialing and Privileging Supervisor. The Director and Deputy Quality Chief/Risk Manager stated that the plan is to expand staffing in the QSV service and hire a permanent risk manager. The Deputy Quality Chief/Risk Manager described the risk manager position as one that requires knowledge of clinical issues and legal liability, as well as effective communication with facility leaders. At the time of the virtual inspection, multiple postings for the position had not yielded applicants with the appropriate knowledge or experience.

## **Veterans Health Administration Performance Data for the Healthcare System**

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.”<sup>33</sup> 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.<sup>34</sup>

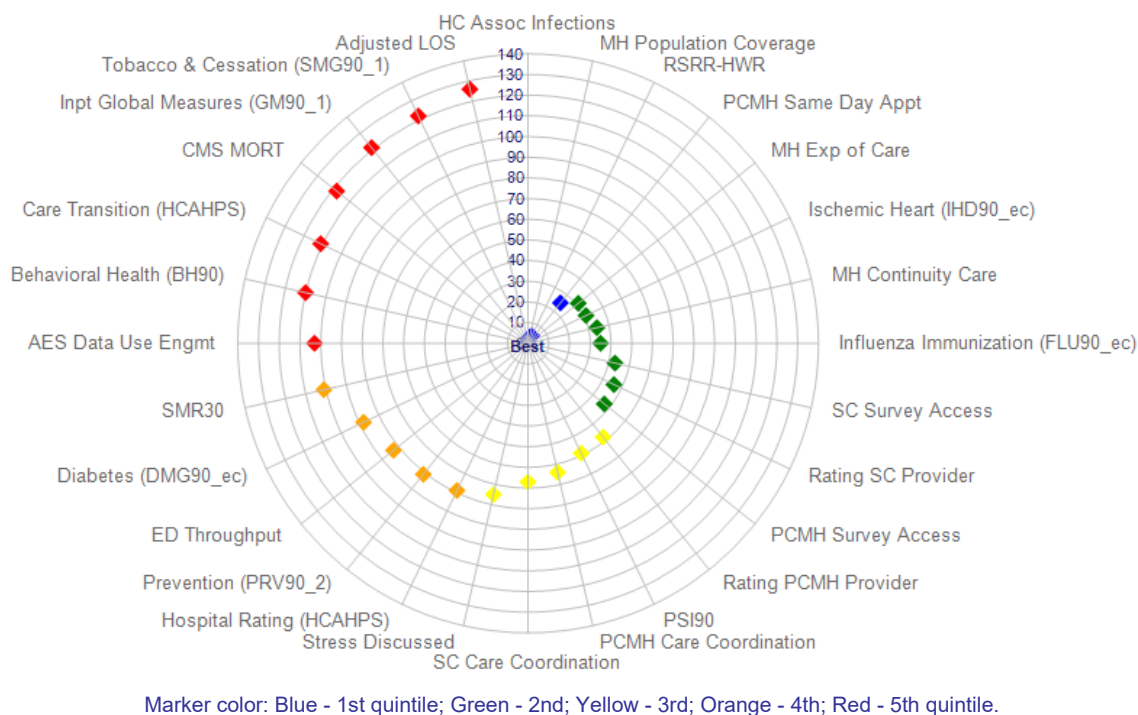
<sup>33</sup> “Strategic Analytics for Improvement and Learning (SAIL) Value Model,” VHA Support Service Center, accessed March 6, 2020, <https://vssc.med.va.gov>. (This is an internal website not publicly accessible.)

<sup>34</sup> “Strategic Analytics for Improvement and Learning (SAIL) Value Model.”



Figure 5 illustrates the system’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020.<sup>35</sup> Figure 5 shows the VA Finger Lakes Healthcare System’s performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, mental health (MH) population coverage, MH continuity (of) care, and rating (of) specialty care (SC) provider). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, stress discussed, care transition (HCAHPS), and adjusted length of stay (LOS)).<sup>36</sup>

System leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures. In individual interviews, system leaders discussed one explanation for the fifth quintile length of stay measure, which was related to supporting other facilities and accepting patients for convalescent care during the pandemic.



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

Source: VHA Support Service Center.

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

<sup>35</sup> The System Director reported that the SAIL data for the healthcare system had been reported under the Bath VAMC starting with FY 2020 quarter 1, and the CLC SAIL data was reported quarterly for each medical center’s CLC.

<sup>36</sup> For information on the acronyms in the SAIL metrics, please see appendix E.

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

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

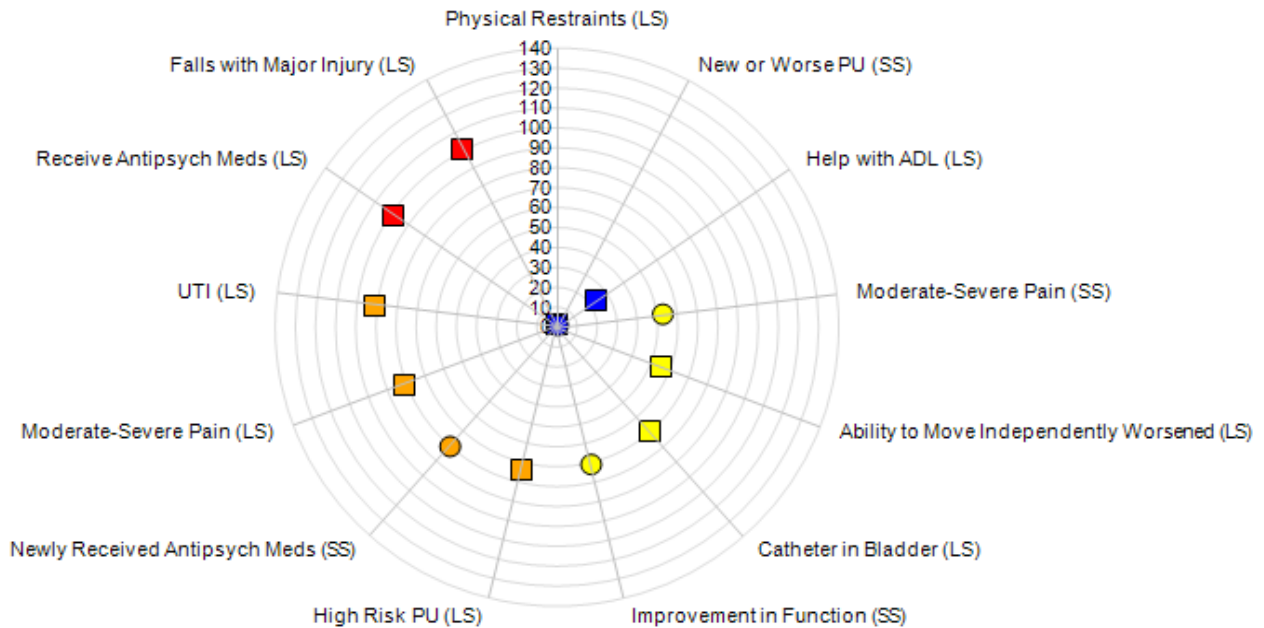
Figures 6 and 7 illustrate the system’s CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. Figure 6 displays the Canandaigua CLC’s metrics with high performance (blue) in the first quintile (physical restraints–long-stay (LS) and new or worse pressure ulcer (PU)–short-stay (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, urinary tract infection (UTI) (LS) and falls with major injury (LS)).<sup>39</sup>

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<sup>37</sup> 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.

<sup>38</sup> 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.”

<sup>39</sup> For data definitions of acronyms in the SAIL CLC measures, please see appendix F.



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

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

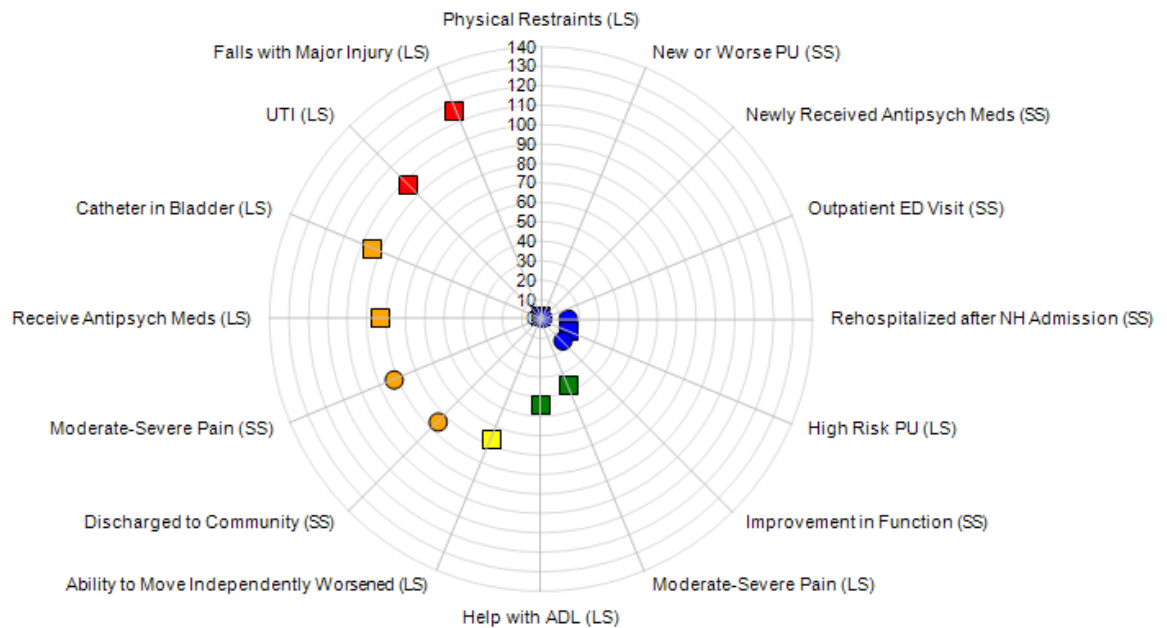
LS = Long-Stay Measure. SS = Short-Stay Measure.

Source: VHA Support Service Center.

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

Figure 7 displays the Bath CLC's metrics with high performance (blue and green data points) in the first and second quintiles (for example, new or worse PU (SS), rehospitized after nursing home (NH) admission (SS), and moderate-severe pain (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, moderate-severe pain (SS), catheter in bladder (LS), and falls with major injury (LS)).<sup>40</sup>

<sup>40</sup> For data definitions of acronyms in the SAIL CLC measures, please see appendix F.



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

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

LS = Long-Stay Measure

SS = Short-Stay Measure

Source: VHA Support Service Center.

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

## Leadership and Organizational Risks Findings and Recommendations

The system’s leaders had worked together for approximately three months at the time of the OIG virtual inspection. System leaders discussed in detail the interim strategies implemented to address clinical and nonclinical occupational shortages.

Selected employee satisfaction survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated. However, scores also demonstrated an opportunity for leaders to improve employee perceptions of servant leadership. Overall patient experience survey data implied satisfaction with the care provided in the outpatient setting, but opportunities for improvement were observed with patients’ willingness to recommend the hospital to family and friends.

The OIG’s review of the system’s accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG noted a vulnerability with the difficulty in staffing the risk manager position at the Canandaigua VAMC. The Deputy Quality Chief/Risk Manager described the risk manager position as one that requires knowledge of clinical issues and legal liability as well as the ability to effectively communicate with system leaders. At the time of the virtual inspection, multiple postings for the position had not yet

yielded applicants with the appropriate knowledge or experience. System leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models.

The OIG made no recommendations.

## COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the “alarming levels of spread and severity” of COVID-19, the World Health Organization declared a pandemic.<sup>41</sup> 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.<sup>42</sup>

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.”<sup>43</sup> “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.”<sup>44</sup>

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

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

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

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<sup>41</sup> “WHO Director-General’s Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020,” World Health Organization, accessed December 8, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

<sup>42</sup> VHA, Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

<sup>43</sup> 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). VA’s missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA’s fourth mission, the “[p]rovision of hospital care and medical services during certain disasters and emergencies...During and immediately following a disaster or emergency...VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency.”

<sup>44</sup> VA OIG, *OIG Inspection of Veterans Health Administration’s COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.<sup>45</sup>

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<sup>45</sup> 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.<sup>46</sup> 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.<sup>47</sup> Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."<sup>48</sup>

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

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

The OIG reviewers also assessed the healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."<sup>49</sup> Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."<sup>50</sup> The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator
- Tracking of facility-level performance improvement capability and projects
- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group
- Staff education on performance improvement principles and techniques

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<sup>46</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

<sup>47</sup> VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

<sup>48</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

<sup>49</sup> VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

<sup>50</sup> VHA Directive 1026.01.



Next, the OIG assessed the healthcare system’s processes for conducting protected peer reviews of clinical care.<sup>51</sup> Protected peer reviews, “when conducted systematically and credibly,” reveal areas for improvement (involving one or more providers’ practices) and can result in both immediate and “long-term improvements in patient care.”<sup>52</sup> Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.<sup>53</sup> The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit<sup>54</sup>
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews<sup>55</sup>
- Quarterly review of the Peer Review Committee’s summary analysis by the Executive Committee of the Medical Staff

The OIG did not conduct the review of selected surgical program requirements because the healthcare system did not have a surgical program.

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, and other relevant information.<sup>56</sup>

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<sup>51</sup> VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a “critical review of care, performed by a peer,” to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. In the context of protected peer reviews, “protected” refers to the designation of review as a confidential quality management activity under 38 U.S.C. § 5705 as “a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities.”

<sup>52</sup> VHA Directive 1190.

<sup>53</sup> VHA Directive 1190.

<sup>54</sup> VHA Directive 1190.

<sup>55</sup> VHA Directive 1190. A peer review is assigned a Level 3 when “most experienced and competent clinicians would have managed the case differently.”

<sup>56</sup> For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

## **Quality, Safety, and Value Findings and Recommendations**

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

## Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of “professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate.”<sup>57</sup> Licensure is defined by VHA as “the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration.”<sup>58</sup>

VA requires all RNs to hold at least one active, unencumbered license.<sup>59</sup> Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.<sup>60</sup> When an action has been “taken against [an] applicant’s sole license or against any of the applicant’s licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA’s licensure requirements,” and documented as required.<sup>61</sup> Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA’s electronic credentialing system, prior to appointment to a VA medical facility.<sup>62</sup>

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and staff and reviewing relevant documents for 25 RNs hired from July 1, 2020, through May 19, 2021. The OIG determined whether

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

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

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<sup>57</sup> VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. VHA Directive 2012-030 was replaced on September 15, 2021, by VHA Directive 1100.20, *Credentialing of Health Care Providers*. The two documents contain similar language regarding credentialing procedures.

<sup>58</sup> VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

<sup>59</sup> VHA Directive 2012-030, replaced by VHA Directive 1100.20. The two documents contain similar language regarding RN licenses. “Definition of *Unencumbered license*,” Law Insider, accessed December 3, 2020, <https://www.lawinsider.com/dictionary/unencumbered-license>. An unencumbered license is “a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action.”

<sup>60</sup> 38 U.S.C. § 7402.

<sup>61</sup> VHA Directive 2012-030, replaced by VHA Directive 1100.20.

<sup>62</sup> VHA Directive 2012-030, replaced by VHA Directive 1100.20.

## **Registered Nurse Credentialing Findings and Recommendations**

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

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.<sup>63</sup> 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.<sup>64</sup> However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.<sup>65</sup>

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.<sup>66</sup> The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.<sup>67</sup> The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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<sup>63</sup> “Suicide Prevention: Facts About Suicide,” Centers for Disease Control and Prevention, accessed October 8, 2021, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

<sup>64</sup> Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.

<sup>65</sup> Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.

<sup>66</sup> Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018; Department of Veterans Affairs, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting*, December 18, 2019.

<sup>67</sup> DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

- the electronic health records of 50 randomly selected patients who were seen in the urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.<sup>68</sup>

## Mental Health Findings and Recommendations

The OIG found the healthcare system had generally complied with the initiation and completion of the Columbia-Suicide Severity Rating Scale. However, the OIG identified a deficiency with staff training.

VHA has identified various staff members who, with proper training, can complete patients' suicide safety plans. Additionally, VHA requires staff who develop these safety plans to complete specific training.<sup>69</sup> The OIG found that 3 of 18 staff (17 percent) reviewed who were responsible for suicide safety plan development had not completed mandatory training. Lack of training could prevent staff from providing optimal treatment to veterans who are at risk for suicide. The Director of Education reported that providers' training profiles had incorrect supervisor information, which resulted in delinquencies not being reported to the current supervisor. Additionally, the Associate Chief of Staff reported being unaware that staff had not completed the training.

### Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that staff complete suicide safety plan training prior to developing suicide safety plans.

Healthcare system concurred.

Target date for completion: September 30, 2022

Healthcare system response: The reasons for noncompliance were considered when developing the action plan; the Chief of Staff's designee coordinated with the Designated Learning Officer to update the list of providers who develop safety plans and assigned them the Talent Management System Suicide Safety Plan Training. The Chief of Staff's designee will monitor training completion and report the results to the Accreditation Readiness Committee and Quality Safety Value Committee until compliance of 90% or greater has been maintained for a minimum of six months.

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<sup>68</sup> The VA Finger Lakes Healthcare System does not have an emergency department. The urgent care center is located at the Bath VAMC.

<sup>69</sup> *VA Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Templates, Staff Specific Guidance*, April 17, 2019. (This document was updated on June 18, 2020. The two versions contain similar language related to training requirements.)

## Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.<sup>70</sup>

VHA medical facility directors are “responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients.”<sup>71</sup> Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.<sup>72</sup>

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

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

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key leaders and staff. The team also reviewed the electronic health records of 48 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

## Care Coordination Findings and Recommendations

The OIG observed general compliance with requirements for completion of the VA *Inter-Facility Transfer Form* or facility-defined equivalent. However, the OIG identified deficiencies with monitoring and evaluation of inter-facility transfers, transmission of medical records to the receiving facility, and communication between nurses at sending and receiving facilities.

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<sup>70</sup> VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

<sup>71</sup> VHA Directive 1094.

<sup>72</sup> VHA Directive 1094. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients’ informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

VHA requires the Chief of Staff and ADPNS to ensure that “all transfers are monitored and evaluated as part of VHA’s Quality Management Program.”<sup>73</sup> The OIG did not find evidence that staff monitored and evaluated patient transfers from June 1, 2020, through May 31, 2021. Failure to monitor patient transfer data could prevent the identification of system-level deficiencies that put patients at risk. The Associate Chief of Staff explained that while completing a review of policies as part of the healthcare system integration between the Bath and Canandaigua VAMCs, it was determined that the monitoring process for inter-facility transfer data did not meet the intent of the directive. The role of transfer coordinator was established and filled within the month prior to the OIG’s virtual inspection; this position is responsible for data monitoring and evaluation.

## Recommendation 2

2. The Chief of Staff and Associate Director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and make certain that all transfers are monitored and evaluated as part of VHA’s Quality Management Program.<sup>74</sup>

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: In May 2021, during a policy revision, the Risk Manager identified the facility’s noncompliance with monitoring of all transfers. The Risk Manager and new Transfer Coordinator developed a process for auditing and reporting all facility transfers. The Transfer Coordinator has monitored the facility transfers and reported the results monthly to the Executive Committee of Medical Staff since June 2021. This committee is chaired by the Chief of Staff and attended by the Associate Director for Patient and Nursing Services. The facility has observed compliance at 90% or greater for a minimum of six months.

VHA requires the Chief of Staff and ADPNS to ensure that transferring physicians or the assigned designees “send all pertinent medical records available, including...documentation of the patient’s advance directive made prior to transfer, if any” to the receiving facility.<sup>75</sup> The OIG found that six electronic health records of patients who had an advance directive lacked evidence that staff sent a copy to the receiving facility. As a result, there was no assurance that receiving facility staff could determine patients’ preferences regarding their health care. Although the Deputy Quality Manager/Risk Manager confirmed the *Inter-Facility Transfer Form* had a drop-

<sup>73</sup> VHA Directive 1094.

<sup>74</sup> The OIG reviewed evidence sufficient to demonstrate that healthcare system leaders had completed improvement actions, and therefore, closed the recommendation before publication of the report.

<sup>75</sup> VHA Directive 1094.



down box for the advance directive element, the Associate Chief of Staff identified lack of attention to detail as the cause for the absence of documentation. Due to the low number of patients identified for this review element, the OIG made no recommendation.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at both the sending and receiving facility.<sup>76</sup> The OIG did not find evidence of communication between nurses for an estimated 27 percent of inter-facility transfers (95% CI:14.90 and 40.43 percent), which is statistically significantly above the 10 percent deficiency benchmark. This could result in staff at the receiving facility lacking the information needed to care for patients. The OIG only found evidence that nurses communicated with the transferring paramedic or with other individuals identified by first name only. The nurse manager could not provide any other evidence that nurse-to-nurse communication occurred and admitted that there was a lack of attention to detail.

### Recommendation 3

3. The Associate Director for Patient and Nursing Services evaluates and determines any additional reasons for noncompliance and ensures nurse-to-nurse communication occurs between sending and receiving facilities.

Healthcare system concurred.

Target date for completion: September 30, 2022

Healthcare system response: In June 2021, the Transfer Coordinator conducted training on patient transfer documentation requirements to nursing staff. The Transfer Coordinator performs 100% chart audits of all transfers; any noncompliance to documentation requirements receives face to face retraining. The Transfer Coordinator reports documentation compliance monthly to the Executive Committee of Medical Staff. This committee is attended by the Associate Director for Patient and Nursing Services who will ensure nursing documentation compliance is at 90% or greater for a minimum of six months. The denominator will be the number of total transfers.

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<sup>76</sup> VHA Directive 1094.

## High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as “behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility.”<sup>77</sup> Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has “committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety.”<sup>78</sup> The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team<sup>79</sup>
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings<sup>80</sup>
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction<sup>81</sup>
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants<sup>82</sup>

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<sup>77</sup> VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

<sup>78</sup> VHA Directive 2012-026.

<sup>79</sup> VHA Directive 2012-026. An employee threat assessment team is “a facility-level, interdisciplinary team whose primary charge is using evidence-based and data-driven practices for addressing the risk of violence posed by employee-generated behavior(s), that are disruptive or that undermine a culture of safety.”

<sup>80</sup> VHA Directive 2012-026. VHA defines a disruptive behavior committee or board as “a facility-level, interdisciplinary committee whose primary charge is using evidence-based and data-driven practices for preventing, identifying, assessing, managing, reducing, and tracking patient-generated disruptive behavior.”

<sup>81</sup> DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018. VA requires each medical facility’s disruptive behavior committee “to use the Disruptive Behavior Reporting System (DBRS) to document a decision to implement an Order of Behavioral Restriction (OBR) and to document notification of a patient when an OBR is issued.”

<sup>82</sup> DUSHOM Memorandum, *Workplace Behavioral Risk Assessment (WBRA)*, October 19, 2012. The Workplace Behavioral Risk Assessment is a “data-driven process that evaluates the unique constellation of factors that affect workplace safety. It enables facilities to make informed, supportable decisions regarding the level of PMDB [Prevention and Management of Disruptive Behavior] training needed to sustain a culture of safety in the workplace.”

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.<sup>83</sup> VHA also requires that employee threat assessment team members complete the appropriate team-specific training.<sup>84</sup> The OIG assessed staff compliance with the completion of required training.

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

### **High-Risk Processes Findings and Recommendations**

The OIG determined that the healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with required member attendance at Disruptive Behavior Committee meetings and staff completion of required training.<sup>85</sup>

VHA requires that the Chief of Staff and ADPNS establish a disruptive behavior committee or board that includes a senior clinician chairperson, clerical and administrative support staff, and representation from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety or risk management, patient advocacy, and the Union Safety Committee.<sup>86</sup> The committee or board is responsible for coordinating with clinicians, recommending amendments to the patients' treatment plans that may reduce the patients' risk of violence, collecting and analyzing disruptive patient incidents, identifying system problems, and recommending to the Chief of Staff other actions related to the problem of patient violence.<sup>87</sup>

The OIG found that the healthcare system had a Disruptive Behavior Committee for both the Bath and Canandaigua medical center campuses, and each held 10 meetings between May 2020 through April 2021. Further, the OIG found that a Prevention and Management of Disruptive Behavior Program representative did not attend any of the meetings at the Canandaigua campus

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<sup>83</sup> DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

<sup>84</sup> DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

<sup>85</sup> The Disruptive Behavior Committee reported to the Accident Review Board, which reported to the Environment of Care Committee.

<sup>86</sup> VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, corrected copy February 3, 2011. (The two versions contain similar language.)

<sup>87</sup> VHA Directive 2010-053.

or 2 of 10 meetings at Bath campus. This could result in a less comprehensive approach when assessing patients' disruptive behavior and carrying out responsibilities. The Prevention and Management of Disruptive Behavior Coordinator explained that the Canandaigua campus consistently lacked a coordinator for the prevention and management of disruptive behavior, and technical and logistical issues in the transition from two medical centers to one healthcare system resulted in attendance deficiencies. The Disruptive Behavior Committee Chair and Prevention and Management of Disruptive Behavior Coordinator reported that they plan to establish one Disruptive Behavior Committee and have the Prevention and Management of Disruptive Behavior Coordinator support both campuses.

#### **Recommendation 4**

4. The Chief of Staff and Associate Director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and make certain that required members attend Disruptive Behavior Committee meetings.

Healthcare system concurred.

Target date for completion: September 30, 2022

Healthcare system response: In September 2021, the Chief of Staff and the Associate Director for Patient and Nursing Services met with the Disruptive Behavior Committee members and communicated the importance of attendance or sending an appropriate representative. A new chair of the Disruptive Behavior Committee was also named. The Chair of the Disruptive Behavior Committee is responsible for reporting the attendance of mandatory members to the Accreditation Readiness Committee monthly. The Accreditation Readiness Committee is attended by the Chief of Staff and Associate Director of Patient and Nursing Services. The Chief of Staff and Associate Director of Patient and Nursing Services will ensure compliance at 90% or greater for a minimum of six months. The denominator is the number of mandatory members of the Disruptive Behavior Committee.

VHA requires employees to complete prevention and management of disruptive behavior training based on the risk level assigned to their work areas.<sup>88</sup> The OIG found that 17 of 30 employees (57 percent) did not complete the required training based on the risk level for their work area. This could result in employees' lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Coordinator reported that each medical center had different risk level assignment processes, and when aligning them across the healthcare system, risk levels changed. The coordinator explained that when the levels changed, some employees were not assigned the

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<sup>88</sup> DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*.

correct corresponding training. The coordinator also stated that some training levels require in-person interactions, which were delayed during the pandemic.

## Recommendation 5

5. The System Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.<sup>89</sup>

Healthcare system concurred.

Target date for completion: November 30, 2022

Healthcare system response: The System Director will ensure compliance with the VISN action plan to meet 90% compliance. The VISN 2 Network Mental Health Lead working with the VISN 2 Network Designated Learning Officer (DLO) will publish monthly Prevention and Management of Disruptive Behaviors (PMDB) training compliance reports. Compliance will be communicated with the System Director via the VISN 2 Action Tracker. The System Director or designee will report with updated monthly action plans if 90% threshold is not met for six consecutive months. This new reconciliation process went into effect January 2022. The numerator is the number of staff who completed the PMDB training at the required level. The denominator is the number of staff required to complete training.

VHA requires members of the Employee Threat Assessment Team to complete specific workplace violence prevention program training.<sup>90</sup> The OIG found that 4 of 11 Employee Threat Assessment Team members (36 percent) did not complete the required training. Lack of training may result in failure to recognize, evaluate, and manage the risk of future workplace violence. The Disruptive Behavior Committee Chair and Director Education/Designated Learning Officer reported being unaware of the required training.

## Recommendation 6

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

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<sup>89</sup> The OIG recognizes that COVID-19 has affected facility operations and makes no comment on the timeline for safely accomplishing this important training.

<sup>90</sup> DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

Healthcare system concurred.

Target date for completion: September 30, 2022

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

## **Report Conclusion**

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

## Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

**Table A.1. Summary Table of Recommendations**

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



Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> <li>• QSV committee</li> <li>• Systems redesign and improvement</li> <li>• Protected peer reviews</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
RN Credentialing	<ul style="list-style-type: none"> <li>• RN licensure requirements</li> <li>• Primary source verification</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	<ul style="list-style-type: none"> <li>• Columbia-Suicide Severity Rating Scale initiation and note completion</li> <li>• Suicide safety plan completion</li> <li>• Staff training requirements</li> </ul>	<ul style="list-style-type: none"> <li>• Staff complete suicide safety plan training prior to developing suicide safety plans.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Care Coordination: Inter-facility Transfers	<ul style="list-style-type: none"> <li>• Inter-facility transfer policy</li> <li>• Inter-facility transfer monitoring and evaluation</li> <li>• Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer</li> <li>• Patient's active medication list and advance directive sent to receiving facility</li> <li>• Communication between nurses at sending and receiving facilities</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse-to-nurse communication occurs between sending and receiving facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Transfers are monitored and evaluated as part of VHA's Quality Management Program.</li> </ul>

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

## Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 2.<sup>1</sup>

**Table B.1. Profile for VA Finger Lakes Healthcare System (528A6)  
(October 1, 2017, through September 30, 2020)**

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
Total medical care budget	\$279,955,629	\$276,680,742	\$324,491,936
Number of:			
• Unique patients	32,575	32,190	30,625
• Outpatient visits	403,606	418,578	350,861
• Unique employees§	634	632	610
Type and number of operating beds:			
• Community living center	201	201	193
• Domiciliary	218	208	170
• Medicine	10	10	10
Average daily census:			
• Community living center	136	196	173
• Domiciliary	173	202	116
• Medicine	3	3	6

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

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

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

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

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

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

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

## Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Elmira, NY	528G4	3,136	1,530	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology Hematology/ Oncology Infectious disease Nephrology Neurology Orthopedics Otolaryngology Podiatry	–	Nutrition Pharmacy Prosthetics Weight management

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

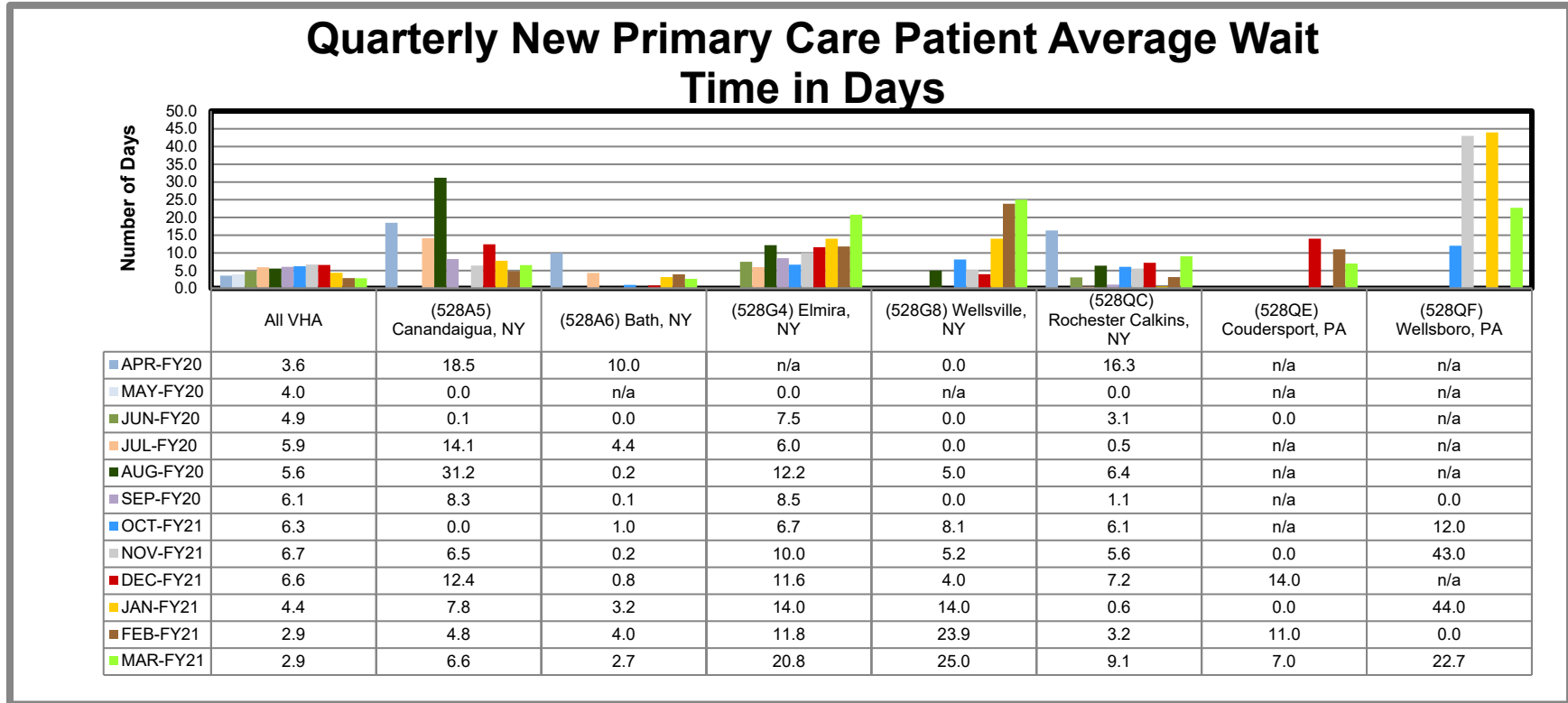
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Elmira, NY (continued)	528G4	3,136	1,530	Pulmonary/ Respiratory disease Rheumatology Urology	–	–
Wellsville, NY	528G8	1,531	708	Anesthesia Dermatology Endocrinology Eye Gastroenterology Hematology/ Oncology Infectious disease Nephrology Neurology Otolaryngology Podiatry Pulmonary/ Respiratory disease Rheumatology	–	Nutrition Pharmacy
Rochester, NY	528GE	610	4,318	Dermatology Gastroenterology Poly-Trauma Rehabilitation physician Vascular	Electrocardiogram (EKG) Radiology	Dental Nutrition Pharmacy Prosthetics Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Rochester, NY	528QC	15,488	4,974	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology Hematology/ Oncology Infectious disease Nephrology Neurology Orthopedics Otolaryngology Podiatry Poly-Trauma Rehabilitation physician Rheumatology Vascular	Electrocardiogram (EKG)	Dental Nutrition Pharmacy Weight management
Coudersport, PA	528QE	615	–	–	–	–
Wellsboro, PA	528QF	1,457	70	Endocrinology Gastroenterology Hematology/ Oncology Rheumatology	–	–

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

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

## Appendix D: Patient Aligned Care Team Compass Metrics

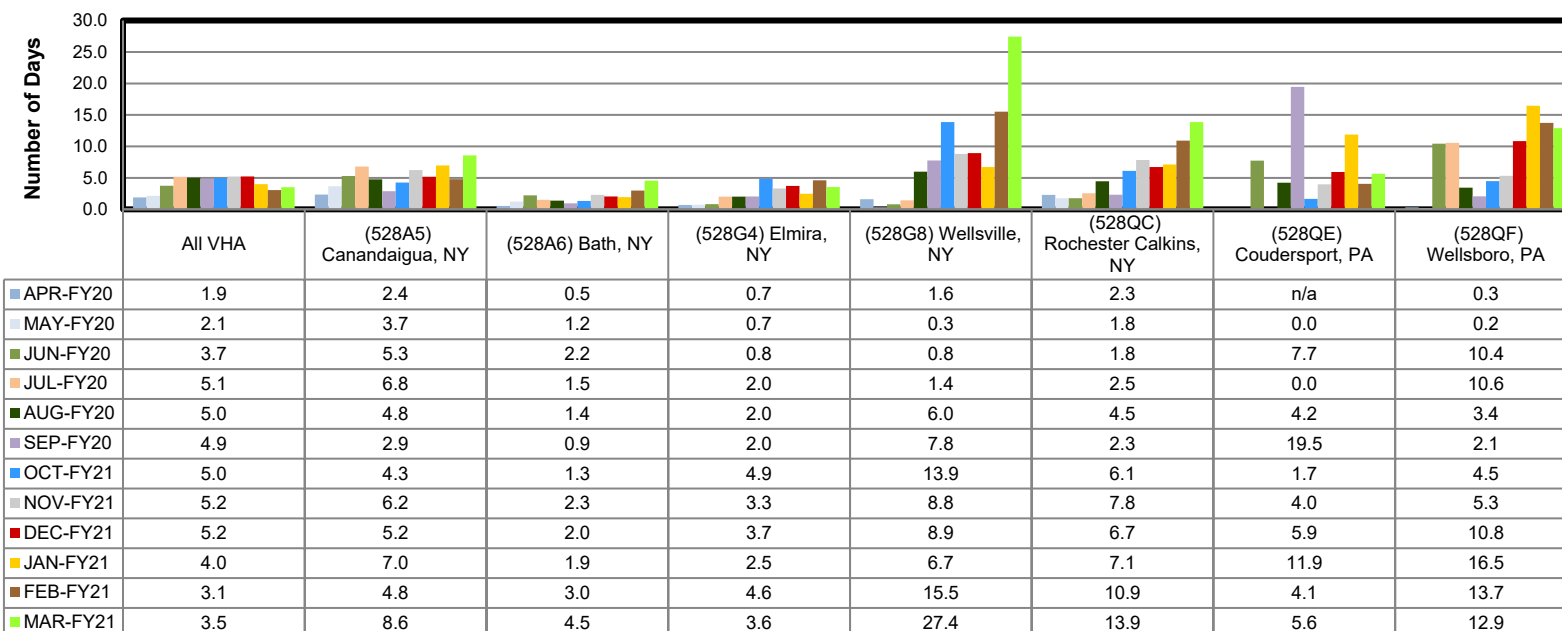


Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, <https://vssc.med.va.gov>, accessed October 21, 2019. (This is an internal website not publicly accessible.)

Note: The OIG did not assess VA’s data for accuracy or completeness. The OIG omitted (528GE) Rochester Clinton Crossings, NY as no data were reported. The OIG has on file the healthcare system leader’s explanation for the increased wait times for the clinic in Wellsboro, PA.

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

## Quarterly Established Primary Care Patient Average Wait Time in Days



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

Note: The OIG did not assess VA’s data for accuracy or completeness. The OIG omitted (528GE) Rochester Clinton Crossings, NY as no data were reported.

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



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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use engmt	Sharing and use of All Employee Survey (AES) data	A higher value is better than a lower value
Behavioral health (BH90)	Healthcare Effectiveness Data and Information Set (HEDIS) outpatient performance measure composite related to screening for depression, posttraumatic stress disorder, alcohol misuse, and suicide risk	A higher value is better than a lower value
Care transition (HCAHPS)	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
Diabetes (DMG90_ec)	HEDIS outpatient performance measure composite for diabetes care	A higher value is better than a lower value
ED throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Healthcare associated infections	A lower value is better than a higher value
Hospital rating (HCAHPS)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Inpt global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	A higher value is better than a lower value

Measure	Definition	Desired Direction
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH population coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	Care coordination (Patient-Centered Medical Home (PCMH))	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH survey)	A higher value is better than a lower value

Measure	Definition	Desired Direction
Tobacco & cessation (SMG90_1)	HEDIS outpatient performance measure composite related to tobacco screening and cessation strategies	A lower value is better than a higher value

Source: VHA Support Service Center.

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

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Discharged to community (SS)	Short-stay measure: percentage of short-stay residents who were successfully discharged to the community.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Outpatient ED visit (SS)	Short-stay measure: percent of short-stay residents who have had an outpatient emergency department (ED) visit.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
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: March 16, 2022

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

Subj: Comprehensive Healthcare Inspection of the VA Finger Lakes Healthcare System in Bath, New York

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

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

Thank you for the opportunity to review the OIG draft report, Comprehensive Healthcare Inspection of the VA Finger Lakes Healthcare System in Bath, New York. I concur with the report findings, recommendations and corrective action plans submitted.

*(Original signed by:)*

Joan E. McInerney, MD, MBA, MA, FACEP

## **Appendix H: Acting Healthcare System Director Comments**

### **Department of Veterans Affairs Memorandum**

Date: March 15, 2022

From: Acting System Director, VA Finger Lakes Healthcare System in Bath, New York  
(528A6/00)

Subj: Comprehensive Healthcare Inspection of the VA Finger Lakes Healthcare  
System in Bath, New York

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

I have reviewed the attached Draft Report for the CHIP Review of the VA Finger Lakes Healthcare System, Bath, New York and concur with this report.

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

Please contact me if you have additional questions or comments.

*(Original signed by:)*

Shawn J. De Fries MS, MBA, RHIA, FACHE

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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<b>Inspection Team</b>	Keri Burgy, MSN, RN, Team Leader Erin Allman, RN, MSN Kimberley De La Cerda, MSN, RN Donna Murray, MSN, RN Teresa Prunte, MHA, BSN Kristie Van Gaalen, BSN, RN Elizabeth Whidden, MS, ARNP Michelle Wilt, MBA, BSN
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<b>Other Contributors</b>	Melinda Alegria, AUD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH Robert Wallace, ScD, MPH
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