DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York

CHIP REPORT | REPORT #21-00295-161 | MAY 25, 2022

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Figure 1. *Samuel S. Stratton VA Medical Center in Albany, New York.*
Source: https://www.va.gov/albany-health-care/ (*accessed February 25, 2022*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CI	confidence interval
CLC	community living center
COS	Chief of Staff
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
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 Samuel S. Stratton VA Medical Center and multiple outpatient clinics in New York. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)[2]
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 Samuel S. Stratton VA Medical Center during the week of July 12, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may

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

[2] 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 Samuel S. Stratton VA Medical Center because staff did not administer remdesivir during the review period.

help this medical center 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 10 recommendations to the Executive Medical Center Director (Director), Chief of Staff, and Associate Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the medical center's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. When the team conducted this inspection, the medical center's leaders had worked together for approximately six months, although multiple leaders had served in their positions for more than two years. The Director, permanently assigned in April 2018, was the most tenured leader. The Associate Director, assigned in January 2021, was the newest member of the leadership team. The Associate Director for Patient Care Services and Chief of Staff had served in their positions since July 2018 and February 2019, respectively.

Organizational communications and accountability were managed through a committee reporting structure, with Leadership Council oversight of several working groups. At the time of the inspection, the Director served as the chairperson of the Leadership Council, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. Leaders monitored patient safety and care through the Quality, Safety and Value Committee, which was responsible for tracking and trending quality of care and patient outcomes.

The medical center's fiscal year 2020 annual medical care budget increased by approximately 21 percent compared to the previous year's budget. The leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Selected employee satisfaction survey responses demonstrated satisfaction with leadership and maintenance of an environment where staff felt respected, and discrimination was not tolerated. Patient experience survey results for outpatient respondents were generally higher than the VHA averages. Both male and female veterans reported lower rates of obtaining appointments needed right away for specialty care. Inpatient survey results revealed that leaders had an opportunity to improve female patients' perceptions of the courtesy and respect they received from nurses, and both male and female patients' perceptions of the courtesy and respect they received from doctors. Inpatients, regardless of gender, were less likely to recommend the hospital to friends and family compared to VHA patients nationally.

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[3] The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to poor performance on specific SAIL measures.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.[4] In individual interviews, the executive leadership team members seemed well-informed about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[5]

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions; the Systems Redesign and Improvement Program; and protected peer reviews.[6] However, the OIG identified weaknesses with surgical work group processes.

Care Coordination

The OIG observed general compliance with documentation of some required transfer elements. However, the OIG identified weaknesses with transfer documentation for patients' informed consent and stability for transfer, transmission of active medication lists and advance directives, and communication between nurses at sending and receiving facilities. The OIG also found noncompliance with the requirements for an inter-facility transfer policy, monitoring and

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

[4] 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."

[5] 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.

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

evaluation of inter-facility transfers, and completion of the required VA *Inter-Facility Transfer Form* or facility equivalent note.[7]

High-Risk Processes

The medical center met many of the requirements for the management of disruptive and violent behavior. However, the OIG noted concerns with Disruptive Behavior Committee meeting attendance, participants' involvement in the annual Workplace Behavioral Risk Assessment, and staff training.

Conclusion

The OIG conducted a detailed inspection across seven key areas (two administrative and five clinical) and subsequently issued 10 recommendations for improvement to the Executive Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address 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 Executive Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 64–65, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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for Healthcare Inspections

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

Contents

Purpose and Scope

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

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

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual 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):[4]

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

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

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

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

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

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

5. Medication management (targeting remdesivir use)[6]
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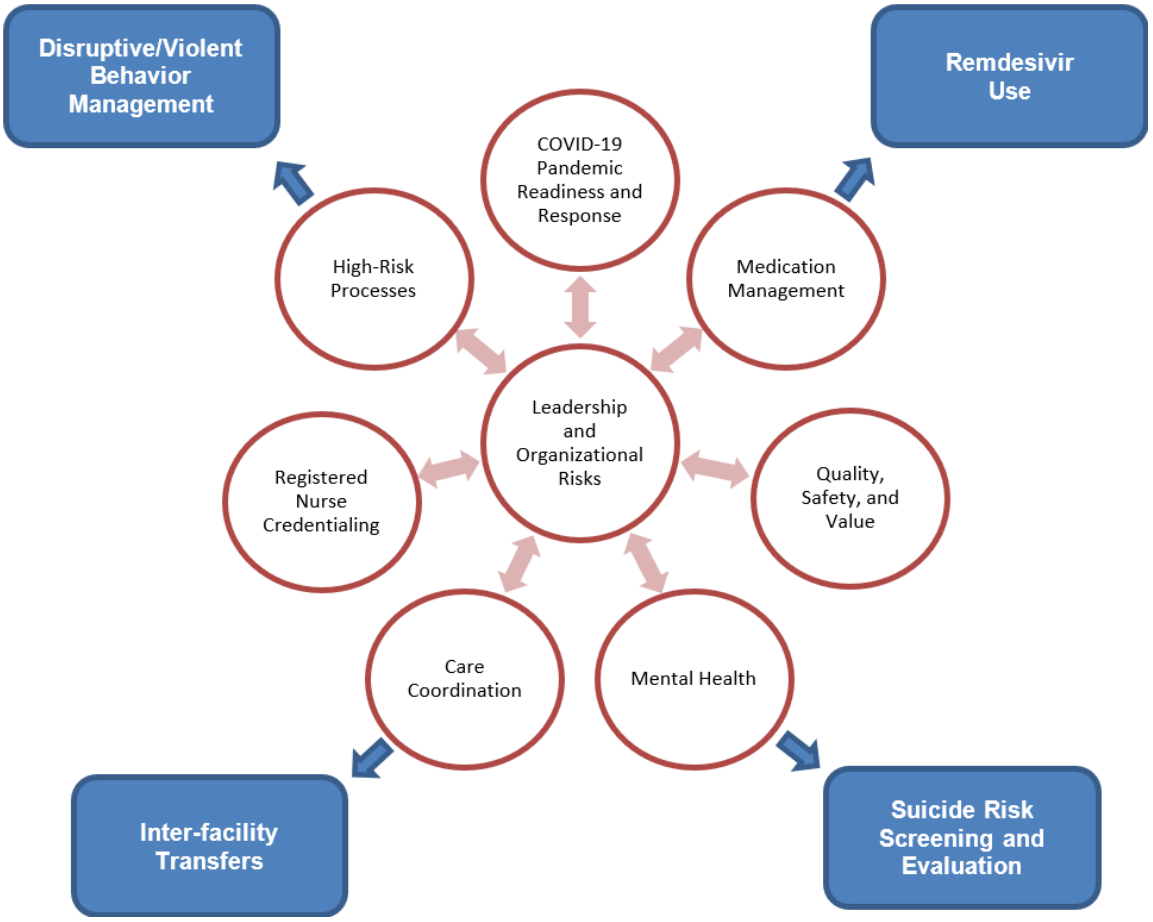


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

[6] 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 Samuel S. Stratton VA Medical Center because staff did not administer remdesivir during the review period.

Methodology

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

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

The inspection examined operations from October 28, 2017, through July 16, 2021, the last day of the unannounced multiday evaluation.[8] 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 medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[9]

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

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

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

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

[9] 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.

[10] 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.[11] To assess this medical center's risks, the OIG considered several indicators:

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

Executive Leadership Position Stability and Engagement

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

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

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

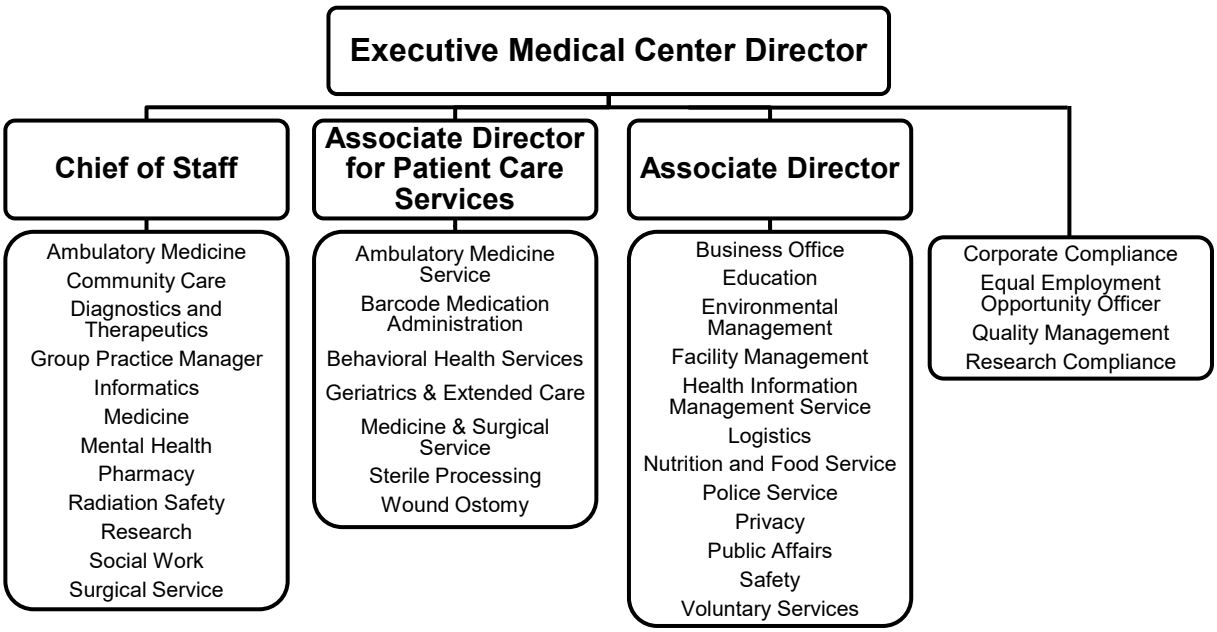


Figure 3. *Medical center organizational chart.*

Source: Samuel S. Stratton VA Medical Center (received July 12, 2021).

At the time of the OIG inspection, the leadership team had worked together for approximately six months, although multiple members had served in their positions for more than two years. The Director and ADPCS were the most tenured leaders. The Associate Director was the newest member of the leadership team but served as a chief information officer for over four years prior to the appointment. The COS had served in the position since February 2019 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Executive Medical Center Director	April 1, 2018
Chief of Staff	February 17, 2019
Associate Director for Patient Care Services	July 8, 2018
Associate Director	January 3, 2021

Source: Samuel S. Stratton VA Medical Center acting Senior Strategic Business Partner (received July 13, 2021).

The Director served as the chairperson of the Leadership Council, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Leadership Council oversaw various working groups such as the Organizational Health; Quality, Safety and Value; and Healthcare Operations Committees, as well as the Executive Committees of the Medical Staff and Nursing Staff. These leaders monitored patient safety and care through the Quality, Safety and Value Committee,

which was responsible for tracking and trending quality of care and patient outcomes and reported to the Leadership Council (see figure 4).

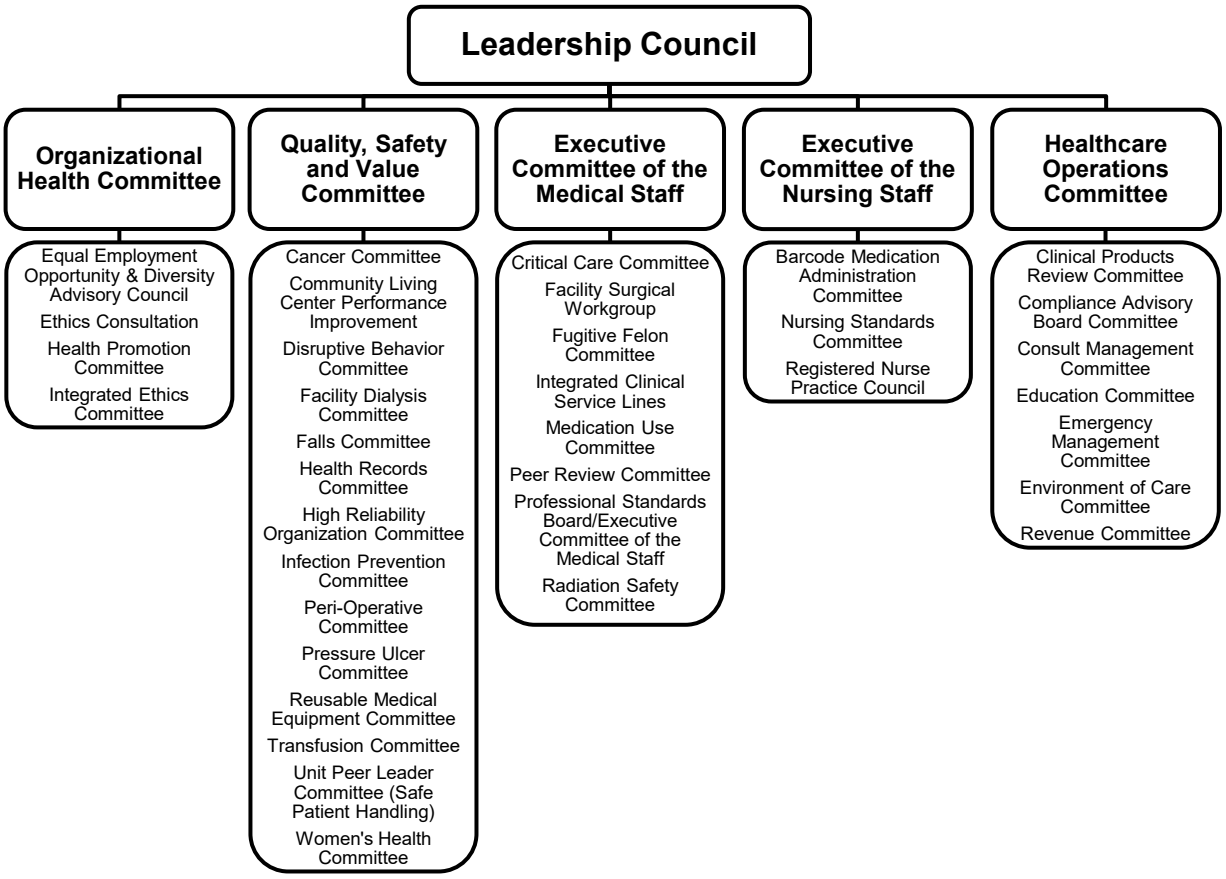


Figure 4. *Medical center committee reporting structure.*

Source: Samuel S. Stratton VA Medical Center (received July 12, 2021).

To help assess the medical center executive leaders' engagement, the OIG interviewed the Director, COS, ADPCS, and Associate Director regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, leaders seemed well-informed about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The medical center's FY 2020 annual medical care budget of $333,116,788 increased by approximately 21 percent compared to the previous year's budget of $276,300,590.[13] When asked about the effect of this change on the medical center's operations, the Director indicated

[13] VA Corporate Data Warehouse.

that the funds were used to improve staffing, support marketing, and acquire additional equipment and resources.

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.[14] 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.[15] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[16]

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*.[17] The Director confirmed that the occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection, except for police and electricians. The COS reported hiring a new service chief and two new staff to address the medical officer shortage. In addition, the COS stated that the urology staff was sufficient to meet patient care needs, but the pulmonary diseases and critical care services staff shortage was a significant impediment to running the intensive care unit. According to the COS, medical center leaders were actively recruiting, working with academic partners, contracting with local providers, and participating in a national tele-intensive care unit that was expected to be operational by fall 2021.[18] The COS also indicated that the medical center had not been fully staffed in anesthesiology since 2011 and was recruiting certified registered nurse anesthetists. Further, the COS discussed concerns with the lower pay level for police officers and noted that a higher salary may be appropriate for the responsibilities of the position and in order to retain staff.

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

[15] 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.

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

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

[18] Department of Veterans Affairs, "Dynamic Port Security Expands VA Tele-Critical Care Capabilities," August 14, 2020, accessed February 28, 2022, https://www.oit.va.gov/news/article/?read=dynamic-port-security-expands-va-tele-critical-care-capabilities. The tele-critical care system, previously known as the tele-intensive care unit (ICU) system, allows "VA Medical Centers (VAMCs) and clinics to access a team of physicians and nurses with critical care medicine expertise. The tele-critical care system includes mobile carts that allow tele-critical care team members to remotely monitor and assess patients, in concert with the bedside care team."

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Medical Officer	1. Police
2. Orthopedic Surgery	2. General Engineering
3. Pulmonary Diseases	3. Boiler Plant Operator
4. Urology	4. Electrician
5. Anesthesiology	5. –

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."[19] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[20] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[21] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. The OIG found that medical center averages for the selected survey leadership questions were similar to or higher than VHA averages. Scores for the executive team were also generally higher than those for VHA and the medical center.[22]

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

[20] "AES Survey History."

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	COS Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	75.1	91.0	87.7	90.7	74.5
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.5	4.4	4.3	3.9	3.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.7	4.2	4.5	4.6	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.8	4.3	4.3	4.3	4.4

Source: VA All Employee Survey (accessed June 14, 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.[23] The medical center averages for the selected survey questions were similar to the VHA averages. Scores for the executive leaders were generally better than VHA and medical center averages.

[23] Ratings are based on responses by employees who report to or are aligned under the Executive Director, COS, ADPCS, and Associate Director.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	COS Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.4	4.5	4.9	4.3
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.4	4.1	4.9	3.8
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.2	1.4	1.3	0.9	1.7

Source: VA All Employee Survey (accessed June 14, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment."[24] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop

[24] "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.[25]

The Director reported implementing strategies from VA's "Stand Up to Stop Harassment Now!" campaign.[26] To demonstrate commitment, the Director stated that employees signed "Stop Harassment" pledges, and the Leadership Council held town halls on this topic and required all supervisors to complete related training.

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	COS Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.6	4.4	4.7	4.3
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.2	4.5	4.7	4.6	4.6
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.2	4.3	4.7	4.3

Source: VA All Employee Survey (accessed June 14, 2021).

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

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

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides survey results for VHA and the medical center.[27] For this medical center, the satisfaction survey results for outpatient respondents were generally higher than VHA averages. Overall, outpatient respondents appeared generally satisfied with the care provided. However, the inpatient survey score was lower than the VHA average, indicating that respondents were less likely to recommend the hospital to friends and family.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	65.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	86.0
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	87.7

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

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[28] 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 (primary care), and Specialty Care surveys (see tables 7–9).

For inpatients, leaders have opportunities to improve both male and female patients' perceptions of courtesy and respect they received from doctors as well as female patients' perceptions of the courtesy and respect they received from nurses. The ADPCS indicated that significant efforts were underway to address inpatient satisfaction by decreasing noise levels to improve sleep. These efforts included leaders ordering both the *Yacker Tracker*, which provides a visual signal of excessive noise levels, and sleep kits that contain eye covers, ear buds, and similar items.[29] Additionally, the ADPCS reported working with patient coordinators on medical center initiatives described as KAIDET (Knock, Announce & Introduce, Duration, Engage, Thank Veteran) and HEART (Hearing, Empathize, Apologize if something went wrong, Responses, Thank Veteran) to improve patient satisfaction. The COS cited the inability to offer private rooms due to the medical center's age and design and the lack of a dedicated inpatient unit for women as contributing factors for the lower scores. To help improve inpatient perceptions of medical providers, the COS described implementing a pilot program in which doctors leave a large format informational card with their contact information and photo at the bedside after visiting a patient's room.

For patient-centered medical home outpatients, as compared with VHA patients nationally, both male and female respondents reported obtaining appointments for care needed right away. For specialty care needed right away, both male and female respondents expressed that they generally did not obtain appointments as soon as needed. The COS reported hiring a new women's health coordinator to help identify and address opportunities to improve female veterans' satisfaction with their providers in both patient-centered medical home and specialty care settings.

[28] "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.

[29] "Yacker Tracker," Attention Getters Inc., accessed February 28, 2022, https://yackertracker.com/.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	68.1	34.7
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	78.4	68.9
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	88.8	80.1

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

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

†*The medical center averages are based on 397–406 male and 29 female respondents, depending on the question.*

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	53.2	47.5
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	61.4	53.1
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	75.2	62.9

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

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

†*The medical center averages are based on 580–2,000 male and 35–102 female respondents, depending on the question.*

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	47.2	34.9
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	57.8	72.8
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	75.0	71.3

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 medical center averages are based on 324–934 male and 23–43 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.[30] Table 10 summarizes the relevant medical center inspections most recently performed by the OIG and The

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

Joint Commission (TJC).[31] TJC conducted their most recent survey of the laboratory and hospital in May and June 2021, respectively. At the time of the OIG inspection, all TJC recommendations remained open, as insufficient time had passed since the surveys. The medical center had closed all OIG CHIP recommendations for improvement issued since the previous site visit conducted in October 2017. The medical center had a focused OIG review in April and May 2020, and two recommendations for improvement directed to VHA's Under Secretary for Health remained open at the time of the OIG visit.

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and additional results from the Long Term Care Institute's inspection of the CLCs.[32]

[31] 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."

[32] 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.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings."

Table 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 (*Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns at the Samuel S. Stratton VA Medical Center, Albany, New York*, Report No. 17-01770-188, August 29, 2018)	February, April, and June 2017	9	0
OIG (*Comprehensive Healthcare Inspection Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York*, Report No. 17-05407-141, March 29, 2018)	October 2017	10	0
OIG (*VHA's Response following Cardiac Catherization Lab Closure at the Samuel S. Stratton VA Medical Center in Albany, New York*, Report No. 19-09129-76, February 17, 2021)	April and May 2020	3	2*
TJC Hospital Accreditation	June 2021	23	23
TJC Behavioral Health Care Accreditation		4	4
TJC Home Care Accreditation		0	0
TJC Laboratory	May 2021	7	7

Source: OIG and TJC (inspection/survey results received from the Quality Manager on July 12, 2021).

**As of February 2022, no recommendations remained open.*

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

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

Table 11 lists the reported patient safety events from October 28, 2017 (the prior OIG CHIP site visit), through July 14, 2021.[33]

Table 11. Summary of Selected Organizational Risk Factors (October 28, 2017, through July 14, 2021)

Factor	Number of Occurrences
Sentinel Events	16
Institutional Disclosures	25
Large-Scale Disclosures	0

Source: VA Samuel S. Stratton VA Medical Center's Patient Safety Manager and Risk Manager (received July 15, 2021).

The Director spoke knowledgeably about serious adverse event reporting, provided assurance that staff were aware of the requirements to raise patient safety concerns, and explained that leaders followed local policies and VHA directives to determine when institutional disclosures were needed. Further, the Director stated that leadership committees tracked issues for serious events, which included developing action plans, identifying the responsible committee or individual, and following up for periodic updates. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.

Veterans Health Administration Performance Data for the Medical Center

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

[33] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The Samuel S. Stratton VA Medical Center is a mid-high complexity (1c) affiliated medical center as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

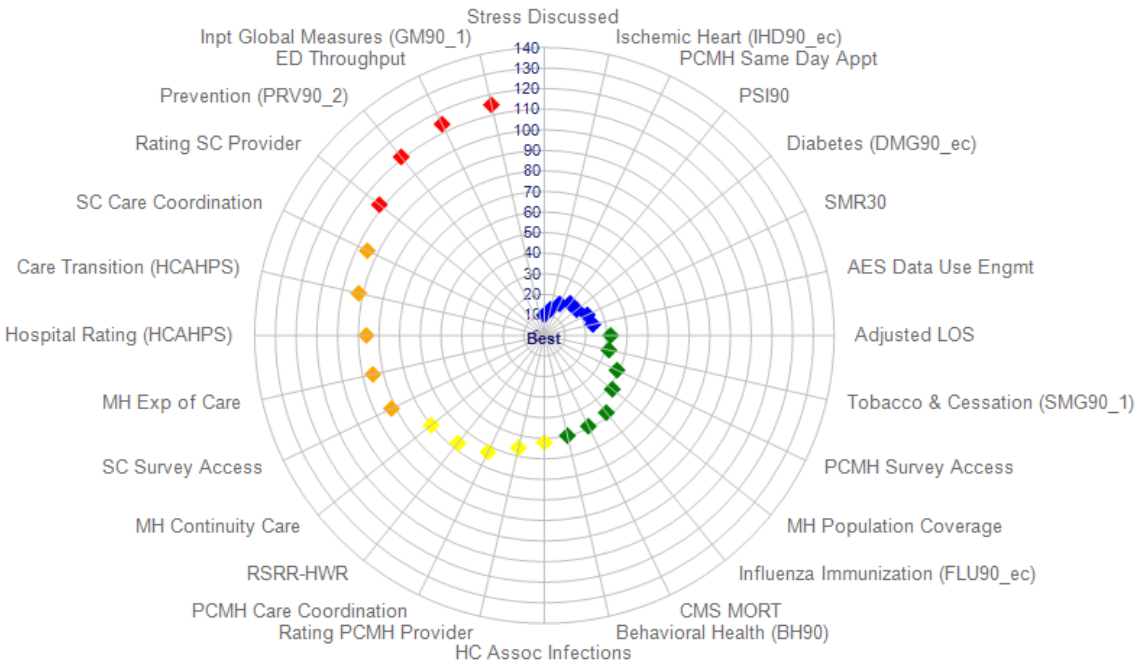
VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[34] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[35]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the 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, stress discussed, adjusted length of stay (LOS), and mental health (MH) population coverage). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, MH experience (exp) of care, rating (of) specialty care (SC) provider, and emergency department (ED) throughput).[36] Executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures. Leaders seemed well-informed about actions taken during the previous 12 months to maintain or improve performance.

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

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

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



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

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

Source: VHA Support Service Center.

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

Veterans Health Administration Performance Data for the Community Living Center

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

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. Figure 6 displays the CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, physical

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

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

restraints–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and moderate-severe pain (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, high risk PU (LS), urinary tract infection (UTI) (LS), and outpatient emergency department (ED) visit (SS)).[39] Executive leaders were knowledgeable about factors contributing to poorly performing CLC SAIL measures and the improvement actions implemented during the previous 12 months.

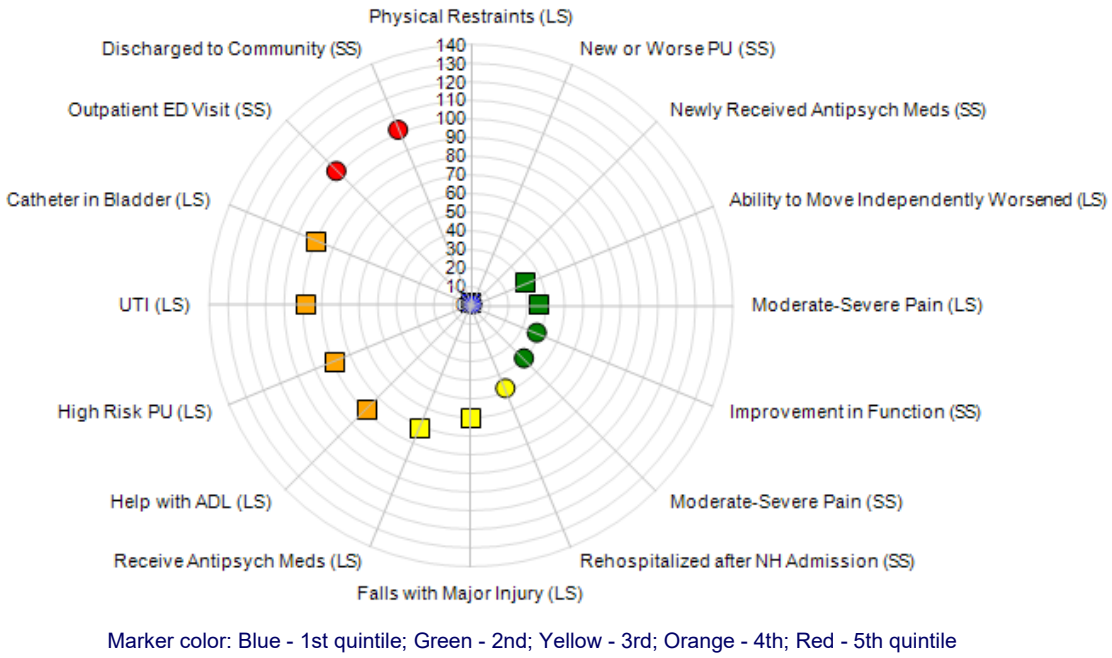


Figure 6. *Samuel S. Stratton CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).*

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 leadership team appeared stable, with all the positions permanently assigned. Leaders had worked together for approximately six months, although multiple leaders had served in their positions for more than two years. The Director, permanently assigned in April 2018, was the most tenured.

At the time of the inspection, the Director served as the chairperson of the Executive Governance Board, which had the authority and responsibility to establish policy, maintain quality care

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

standards, and perform organizational management and strategic planning. The medical center's FY 2020 annual medical care budget increased by approximately 21 percent compared to the previous year's budget. The leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Selected employee survey responses revealed satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated. Patient experience survey results for outpatients were generally higher than the VHA averages. As compared to VHA patients nationally, both male and female veterans reported obtaining appointments for primary care needed right away. However, both genders expressed that they generally did not obtain specialty care appointments as soon as needed. For inpatients, survey results revealed that leaders had an opportunity to improve both male and female patients' perceptions of the courtesy and respect they received from doctors and female patients' perceptions of the courtesy and respect they received from nurses. Inpatients, regardless of gender, were less likely to recommend the hospital when compared to VHA inpatients nationally.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. Leaders were knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to poor performance on specific SAIL measures. In individual interviews, the executive leadership team members seemed well-informed about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[40] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[41]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[42] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[43]

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

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

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

[40] "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed December 8, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

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

[42] 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the "[p]rovision of hospital care and medical services during certain disasters and emergencies…During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

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

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[44]

[44] 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.[45] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain TJC accreditation.[46] 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."[47]

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

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

The OIG reviewers also assessed the medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[48] 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."[49] 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

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

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[50] 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."[51] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[52] 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[53]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[54]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[55] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities;

[50] 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."

[51] VHA Directive 1190.

[52] VHA Directive 1190.

[53] VHA Directive 1190.

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

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[56] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[57]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[58]

Quality, Safety, and Value Findings and Recommendations

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

VHA requires medical facility directors to ensure that facilities have a surgical work group that includes the COS, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[59] The OIG reviewed Facility Surgical Work Group meeting minutes for April 2020 through March 2021 and found that the COS did not attend 11 of 12 work group meetings (92 percent). The lack of core member attendance may have resulted in missed opportunities for oversight and review of surgery program activities with key staff. The COS reported reviewing Facility Surgical Work Group meeting minutes in lieu of attending due to competing priorities. Further, the COS stated that prior experience as the Chief of Surgery and confidence in the current Interim Chief of Surgery contributed to the decision to forgo attendance.

Recommendation 1

1. The Executive Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that the Chief of Staff attends Facility Surgical Work Group meetings.

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

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

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

[59] VHA Directive 1102.01(2).

Medical center concurred.

Target date for completion: December 1, 2022

Medical center response: The Executive Medical Center Director evaluated the reasons for non-compliance and determined there were no additional reasons for non-compliance. The Facility Surgical Work Group (FSWG) continues to meet on a monthly schedule. The FSWG core members (Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager) and qualified alternate members are identified to ensure back-up coverage when a primary member is unable to attend. Core Members were educated on the required monthly participation in the FSWG meetings. Attendance is tracked and recorded at each meeting by the FSWG Minutes Recorder. Quality Management Staff will audit the FSWG minutes and verify documentation of core members attendance until a 90 percent or greater compliance is sustained for six consecutive months. This will be monitored monthly in the Quality, Safety, and Value Committee meeting, chaired by the Executive Medical Center Director.

VHA requires medical facilities that have surgery programs to have a surgical work group responsible for the "monthly review of surgical deaths; an analysis of efficiency and utilization metrics; an identification of gaps within current surgical care; a review of NSO [National Surgery Office] surgical quality reports; and an evaluation of critical surgical events."[60] The OIG reviewed Facility Surgical Work Group meeting minutes for April 2020 through March 2021 and did not find evidence that the group consistently reviewed National Surgery Office surgical quality reports. Failure to consistently review and analyze surgical data may have resulted in missed opportunities to improve patient safety in the surgical program. The Interim Chief of Surgery stated that the work group overlooked the need to review all elements of the National Surgery Office reports during meetings; however, the group evaluated portions of the reports during discussions of other agenda items.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that the Facility Surgical Work Group reviews National Surgery Office surgical quality reports.

[60] VHA Directive 1102.01(2).

Medical center concurred.

Target date for completion: December 1, 2022

Medical Center response: The Chief of Staff evaluated the reasons for non-compliance and determined there were no additional reasons for non-compliance. The Chief of Surgery will ensure that the group consistently reviews the National Surgery Office surgical quality reports in the FSWG meeting. Quality Management Staff will audit the FSWG minutes and verify that the National Surgery office report is reviewed in totality with outcomes until a 90 percent or greater compliance is sustained for six consecutive months. This will be monitored monthly in the Quality, Safety, and Value Committee meeting, chaired by the Executive Medical Center Director.

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."[61] 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."[62]

VA requires all RNs to hold at least one active, unencumbered license.[63] 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.[64] 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.[65] 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.[66]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 32 RNs hired from July 1, 2020, through June 13, 2021. The OIG determined whether

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

The OIG also reviewed the credentialing files for 30 of the 32 RNs to determine whether medical center staff completed primary source verification prior to the appointment.

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

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

[63] 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."

[64] 38 U.S.C. § 7402.

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

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

Registered Nurse Credentialing Findings and Recommendations

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

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.[67] 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.[68] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[69]

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.[70] 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.[71] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

[70] 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.

[71] 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 45 randomly selected patients who were seen in the emergency department or urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[72]

VHA medical center directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients."[73] 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.[74]

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

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

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 38 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with documentation of some required transfer elements (reason for the transfer, date and time transfer would occur, and identification of the receiving physician). However, the OIG noted deficiencies with documentation of patients' informed consent and stability for transfer, transmission of active medication lists and advance directives, and communication between nurses at sending and receiving facilities. Additionally, the OIG

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

[73] VHA Directive 1094.

[74] 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.

identified noncompliance with requirements for an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, and completion of the required VA *Inter-Facility Transfer Form* or facility equivalent note.

At the time of the virtual inspection, VHA required the Medical Center Director (Director) or designee to ensure a written policy was in place for "the safe, appropriate, orderly, and timely transfer of patients."[75] The Quality Specialist reported that the medical center did not have a policy for inter-facility transfers. Failure to maintain a current inter-facility transfer policy could have resulted in lack of coordination between facilities to provide seamless care for patients. The Quality Specialist reported being unaware of the requirement prior to February 2021 but had since created a draft policy and was seeking input from all stakeholders.[76]

Recommendation 3

3. The Executive Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that a written policy is in place to ensure the safe, appropriate, orderly, and timely transfer of patients.

[75] VHA Directive 1094.

[76] On January 20, 2022, VHA updated its inter-facility transfer directive and removed the requirement for medical facilities to have a written policy; therefore, the OIG did not issue a recommendation. However, after the OIG issued the draft report to the medical center, VHA removed the updated directive from circulation and reposted the previous version dated January 11, 2017, pending legal review of the revised policy. As a result, the OIG issued a recommendation based on requirements in the 2017 directive.

Medical center concurred.

Target date for completion: August 30, 2022

Medical center response: The Executive Medical Center Director evaluated any additional reasons for noncompliance and will ensure completion of the facility specific policy for Inter-Facility Transfers and provider training to be completed by August 30, 2022. The facility's initial response included creating a draft Interfacility Transfer Medical Center Policy for approval. At time of completion, VHA Directive 1094 Inter-Facility Transfer Policy dated January 11, 2017, was removed by national and replaced with VHA Directive 1094 Inter-Facility Transfer Policy dated January 20, 2022, which removed the mandate to have a local facility policy. Instead, VHA Directive 1094, January 20, 2022, required a standard operating procedure (SOP). The medical center policy was changed to a standard operating procedure and approved by medical and nursing leadership. At time of final pentad approval, VHA Directive 1094, January 20, 2022, was removed and replaced with the previous version of VHA Directive 1094, January 11, 2017, requiring a medical center policy. Currently changing the Interfacility Transfer standard operating procedure to a medical center policy. The VISN 2 "Interfacility Transfer Note" template was updated to include all documentation requirements and was released for use in the electronic health record system on April 18, 2022. The Chief of Staff will ensure implementation of the facility specific policy for Inter-Facility Transfers and provider training with use of the new templated VISN note to be completed by August 30, 2022.

VHA requires the COS and ADPCS to ensure that "all transfers are monitored and evaluated as part of VHA's Quality Management Program."[77] The Quality Specialist reported that medical center staff did not monitor and evaluate transfers. Failure to monitor and evaluate patient transfer data could prevent staff from identifying system-level deficiencies that put patients at risk. The Quality Specialist reported that managers were unaware of the requirement and leaders had not assigned staff to oversee the inter-facility transfer process until February 2021.

Recommendation 4

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

[77] VHA Directive 1094.

Medical center concurred.

Target date for completion: December 1, 2022

Medical center response: The reasons for noncompliance were considered by the Chief of Staff when developing the action plan to ensure the presence of a facility written policy for Interfacility Transfers. The Director's designee determined the facility was using VHA Directive 1094 Inter-Facility Transfer Policy dated January 11, 2017, as their guide. The Executive Medical Center Director and Chief of Staff will ensure completion of the facility specific policy for Inter-Facility Transfers by August 30, 2022. The Health Systems Specialist assigned to the Chief of Staff's office will monitor and report data on Interfacility transfers monthly in the Quality, Safety, and Value Committee meeting, chaired by the Executive Medical Center Director until a 90 percent or greater compliance is sustained for six consecutive months.

VHA requires providers to complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record prior to the patient transfer.[78] The OIG estimated that 97 percent of records (95% CI: 91.2 and 100.0 percent) did not complete a VA *Inter-Facility Transfer Form* or a facility-defined equivalent note prior to the patient transfer, which is statistically significantly above the 10 percent deficiency benchmark. VHA also requires transferring providers to record specific elements in the transfer form, such as patients' informed consent and medical stability for transfer.[79] The OIG estimated that transferring providers did not document patients' informed consent and medical stability for 95 percent (95% CI: 86.5 and 100.0 percent) and 50 percent (95% CI: 34.2 and 65.8 percent) of inter-facility transfers, respectively, which is statistically significantly above the 10 percent deficiency benchmark. These deficiencies could result in the unsafe transfer of patients to other healthcare facilities. The Emergency Department Section Chief reported that providers were unaware of the requirements due to the lack of staff assigned to oversee the inter-facility transfer process.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that transferring providers complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note to include required elements in the electronic health record prior to patient transfers.

[78] VHA Directive 1094.

[79] VHA Directive 1094.

Medical center concurred.

Target date for completion: December 1, 2022

Medical center response: The Chief of Staff, in collaboration with the Associate Director for Patient Care Services (ADPCS), will ensure that all relevant staff, including providers, receive training to complete all required elements on the VA Inter-Facility Transfer Form 10-2649A located in the transfer note. The available Computerized Patient Record System (CPRS) template will be used to ensure all required elements of the transfer form are met. The Clinical Applications Coordinator (CAC) will ensure the template is available for use at the facility. In April 2022, the facility will start auditing 100% of transfer records. While hard stops ensure completion of the form, the Chief of Staff's Health System Specialist will monitor compliance with the VA Inter-Facility Transfer Form or equivalent note. Audit results will be reported to the Chief of Staff and the ADPCS monthly in the Quality, Safety, and Value Committee until a 90 percent or greater compliance is sustained for six consecutive months. Compliance will be submitted to the VISN Quality Safety Value Committee quarterly.

VHA requires transferring providers to "send all pertinent medical records available, including an active patient medication list and…documentation of the patient's advance directive" to the receiving facility during inter-facility transfers.[80] The OIG estimated that 97 percent of electronic health records (95% CI: 90.3 and 100.0 percent) lacked evidence that transferring providers sent an active medication list to the receiving facility, which is statistically significantly above the 10 percent deficiency benchmark. Additionally, the OIG determined that providers did not send a copy of the advanced directive to the receiving facility for any of the 11 applicable patients. This may result in suboptimal treatment decisions that compromise patient safety. The Emergency Department Section Chief and Nurse Manager reported being unaware of the requirements because staff were not assigned to oversee the inter-facility transfer process. Due to the low number of patients identified for the advance directive requirement, the OIG made no recommendation.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that transferring providers send patients' active medication lists to receiving facilities during inter-facility transfers.

[80] VHA Directive 1094.

Medical center concurred.

Target date for completion: December 1, 2022

Medical center response: The Chief of Staff and ADPCS will ensure that the emergency department/inpatient Medical Support Assistant during regular business hours and the Administrative Officer of the Day outside business hours will use the updated "Interfacility Transfer Document List" to include the VA Inter-Facility Transfer Form, Advance Directives, and active Medication List and add a checkbox and mark as sent with the patient. When completed, the Medical Support Assistant or Administrative Officer of the Day will then scan the "Interfacility Transfer Document List" into the patient's electronic health record as evidence of records sent. The Chief of Staff's Health System Specialist will audit compliance with the tracking of this improvement action and report to the Chief of Staff monthly in the Quality, Safety, and Value Committee until a 90 percent or greater compliance is sustained for six consecutive months. Compliance will be submitted to the VISN Quality Safety Value Committee quarterly.

VHA states that communication between nurses during the inter-facility transfer process is essential and allows for questions and answers from staff at both sending and receiving facilities.[81] The OIG did not find evidence of this communication in an estimated 32 percent of inter-facility transfers (95% CI: 17.2 and 46.4 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 Emergency Department Nurse Manager stated that lack of awareness of the requirement resulted in inconsistent documentation.

Recommendation 7

7. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that nurse-to-nurse communication occurs between the sending and receiving facility.

[81] VHA Directive 1094.

Medical center concurred.

Target date for completion: December 1, 2022

Medical center response: The ADPCS will ensure oversight of nurse-to-nurse communication between the sending and receiving facilities. The sending nurse must document in the Nursing Transfer Note or in the interfacility transfer section of the emergency room Nursing Note, the name of the nurse taking the report in the receiving facility. The Chief of Staff's Health System Specialist will audit compliance with the tracking of this improvement action until 90 percent or greater compliance is sustained for 6 consecutive months with progress being reported to the ADPCS monthly in the Quality, Safety, and Value Committee. Compliance will be submitted to the VISN Quality Safety Value Committee quarterly.

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."[82] 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."[83] 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[84]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[85]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[86]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[87]

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

[83] VHA Directive 2012-026.

[84] 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."

[85] 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."

[86] 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."

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

VHA requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[88] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[89] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The medical center met many of the requirements for the management of disruptive and violent behavior. However, the OIG noted concerns with Disruptive Behavior Committee meeting attendance, participants' involvement in the annual Workplace Behavioral Risk Assessment, and staff training.

VHA requires the COS and Nurse Executive (ADPCS) to establish a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; the patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the Union Safety Committee.[90] The committee or board is responsible for coordinating with clinicians, recommending amendments to patients' treatment plans that may reduce the patients' risk of violence, collecting and analyzing disruptive patient incidents, "identifying system problems, and recommending to the COS other actions related to the problem of patient violence."[91]

The OIG reviewed attendance for Disruptive Behavior Committee meetings held from April 2020 through March 2021 and found that the Prevention and Management of Disruptive Behavior Program representative did not attend any of the 21 meetings. This could result in the committee taking a less comprehensive approach when assessing patients' disruptive behavior and carrying out other responsibilities. The Chairs of the Disruptive Behavior Committee and Employee Threat Assessment Team stated that medical center leaders had not appointed a new prevention and management of disruptive behavior coordinator since the departure of the

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

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

[90] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, Corrected Copy February 3, 2011.

[91] VHA Directive 2010-053.

Education Specialist/Prevention and Management of Disruptive Behavior Coordinator in early 2020.

Recommendation 8

8. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure the Prevention and Management of Disruptive Behavior Program representative attends Disruptive Behavior Committee meetings.

Medical center concurred.

Target date for completion: August 1, 2022

Medical center response: The Facility Director appointed a new Prevention and Management of Disruptive Behavior Program Manager. The Chair of the Disruptive Behavior Committee (DBC) will capture attendance at the beginning of each committee meeting for each required member. All core members of the DBC have designated at least one alternate representative to be present at all DBC meetings. Committee members have been instructed to alert the DBC Chair and Co-chair of their absence and ensure an alternate representative will be present. The Chair of the DBC, or designee, will monitor the DBC minutes each month to ensure there is documented evidence of all required members' attendance. Monitoring will continue until a 90 percent compliance is sustained for six (6) consecutive months. This will be reported to the Chief of Staff monthly in the Quality, Safety, and Value Committee for oversight.

VHA requires facility staff to conduct a Workplace Behavioral Risk Assessment each fiscal year.[92] The Workplace Behavioral Risk Assessment is used to assign training based on the risk for exposure to disruptive behaviors and must be completed by an interdisciplinary team that includes the disruptive behavior committee chair, VA police, and a patient safety representative.[93] The OIG found that for FY 2020, the Workplace Behavioral Risk Assessment did not include VA police or a patient safety representative. This could result in inadequate staff training or security precautions in areas at risk. The Chair of the Disruptive Behavior Committee reported being unaware that VA police and a patient safety representative were required participants.

[92] DUSHOM Memorandum, *Meeting New Mandatory Safety Training Requirements using VHA's Prevention and Management of Disruptive Behavior (PMDB) Curriculum*, November 7, 2013.

[93] DUSHOM Memorandum, *Workplace Behavioral Risk Assessment (WBRA)*, October 19, 2012.

Recommendation 9

9. The Executive Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that the annual Workplace Behavioral Risk Assessment includes participation by VA police and a patient safety representative.

Medical center concurred.

Target date for completion: November 30, 2022

Medical center response: The Chair of the Disruptive Behavior Committee (DBC) will capture attendance at the beginning of each committee meeting for each required member. The Workplace Behavioral Risk assessment (WBRA) was completed outside of the traditional committee with core membership on an annual basis. The DBC Chair will ensure documentation of the Patient Safety Manager and the police participation in completing the WBRA prior to DBC committee review and submission of the report. This will be completed in November 2022.

VHA requires that staff are assigned prevention and management of disruptive behavior training at hire based on the risk level assigned to their work area.[94] The OIG found that 22 of 30 selected staff (73 percent) did not complete required training. This could result in lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Chair of the Disruptive Behavior Committee stated that staff did not complete training due to COVID-19 pandemic-related patient care responsibilities and leaders' guidance to cease face-to-face training to prevent exposure.

Recommendation 10

10. The Executive Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[95]

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

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

Medical center concurred.

Target date for completion: December 1, 2022

Medical center response: The Executive Medical Center Director evaluated any additional reasons for noncompliance in developing this action plan. The initial facility response included verification of assignment of a Prevention and Management of Disruptive Behavior (PMDB) Coordinator, review of level 1, 2 and 3 education status of all facility employees, and number of facility master trainers. The PMDB coordinator and VISN 2 Network Designated Learning Officer (DLO)/education office developed an action plan to enhance the master trainer list and track completion of staff education requirements with priority on high-risk area employees. The PMDB education group will meet monthly to review tracking data and report monthly in the Quality, Safety, and Value Committee for oversight until a 90 percent or greater compliance is sustained for six consecutive months. The VISN 2 Network Mental Health Lead, working with the VISN 2 Network DLO, will publish monthly PMDB training compliance reports. Compliance will be communicated with the facility Executive Medical Center Director via the VISN 2 Action Tracker. The facility will then use the VISN reports, through the Disruptive Behavior Committee, to ensure that trainings are completed for all high-risk areas.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed review of seven clinical and administrative areas and provided 10 recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered at this medical center. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines 10 OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Executive Medical Center Director, COS, and ADPCS. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

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

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• The Facility Surgical Work Group reviews National Surgery Office surgical quality reports.	• The COS attends Facility Surgical Work Group meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• Transferring providers complete the VA *Inter-Facility Transfer Form* or facility-defined equivalent note in the electronic health record prior to patient transfers. • Transferring providers send patients' active medication lists to receiving facilities. • Nurse-to-nurse communication occurs between the sending and receiving facility.	• A written policy is in place to ensure the safe, appropriate, orderly, and timely patient transfers. • Staff monitor and evaluate all transfers as part of VHA's Quality Management Program.

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• The Prevention and Management of Disruptive Behavior Program representative attends Disruptive Behavior Committee meetings. • VA police and a patient safety representative participate in the annual Workplace Behavioral Risk Assessment. • Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

Appendix B: Medical Center Profile

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

Table B.1. Profile for Samuel S. Stratton VA Medical Center (528A8) (October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
Total medical care budget	$248,883,083	$276,300,590	$333,116,788
Number of:			
• Unique patients	35,545	35,780	36,326
• Outpatient visits	383,166	395,438	349,714
• Unique employees§	1,262	1,277	1,242
Type and number of operating beds:			
• Community living center	50	50	50
• Domiciliary	12	12	12
• Medicine	32	32	32
• Mental health	12	12	12
• Surgery	12	11	11

[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) VHA medical centers are classified according to a facility complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." An affiliated medical center is associated with a medical residency program.

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
Average daily census:			
• Community living center	40	45	42
• Domiciliary	10	10	6
• Medicine	24	29	30
• Mental health	6	9	9
• Surgery	7	6	5

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

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

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Westport, NY	528G2	1,132	170	Dermatology Endocrinology Nephrology Neurology Poly-trauma	–	Nutrition Pharmacy
Bainbridge, NY	528G3	1,913	512	Dermatology Nephrology Neurology Pulmonary/ Respiratory disease	Nuclear medicine	Nutrition

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Fonda, NY	528G6	1,925	412	Dermatology Endocrinology Hematology/ Nephrology Neurology Oncology Poly-trauma Pulmonary/ Respiratory Disease Rheumatology	Nuclear medicine	Nutrition
Catskill, NY	528G7	2,415	374	Dermatology Nephrology Neurology Pulmonary/ Respiratory Disease Orthopedics Rheumatology	–	Nutrition Social work
Glens Falls, NY	528GT	4,323	855	Endocrinology Gastroenterology Infectious Disease Nephrology Neurology	Nuclear medicine	Nutrition Pharmacy Social work

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Plattsburgh, NY	528GV	3,265	992	Anesthesia Dermatology Endocrinology Gastroenterology Infectious Disease Nephrology Neurology Plastic surgery Poly-trauma	–	Nutrition Pharmacy
Schenectady, NY	528GW	2,709	268	Dermatology Endocrinology Nephrology Neurology Poly-trauma	–	Nutrition Pharmacy
Troy, NY	528GX	1,880	115	Dermatology Neurology Pulmonary/ Respiratory Disease Rheumatology	–	Pharmacy Social work
Clifton Park, NY	528GY	2,034	85	Dermatology Endocrinology Nephrology Neurology Pulmonary/ Respiratory Disease	–	Nutrition Pharmacy

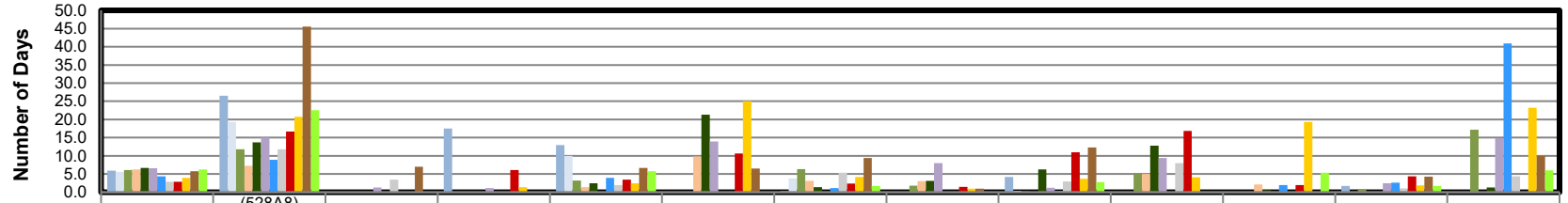
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Kingston, NY	528GZ	2,454	961	Anesthesia Endocrinology Gastroenterology Nephrology Neurology Poly-trauma Rheumatology	–	Nutrition Pharmacy Social work
Saranac Lake, NY	528QK	1,409	288	Dermatology Endocrinology Gastroenterology Nephrology Neurology Poly-trauma	Nuclear medicine	Nutrition Pharmacy

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

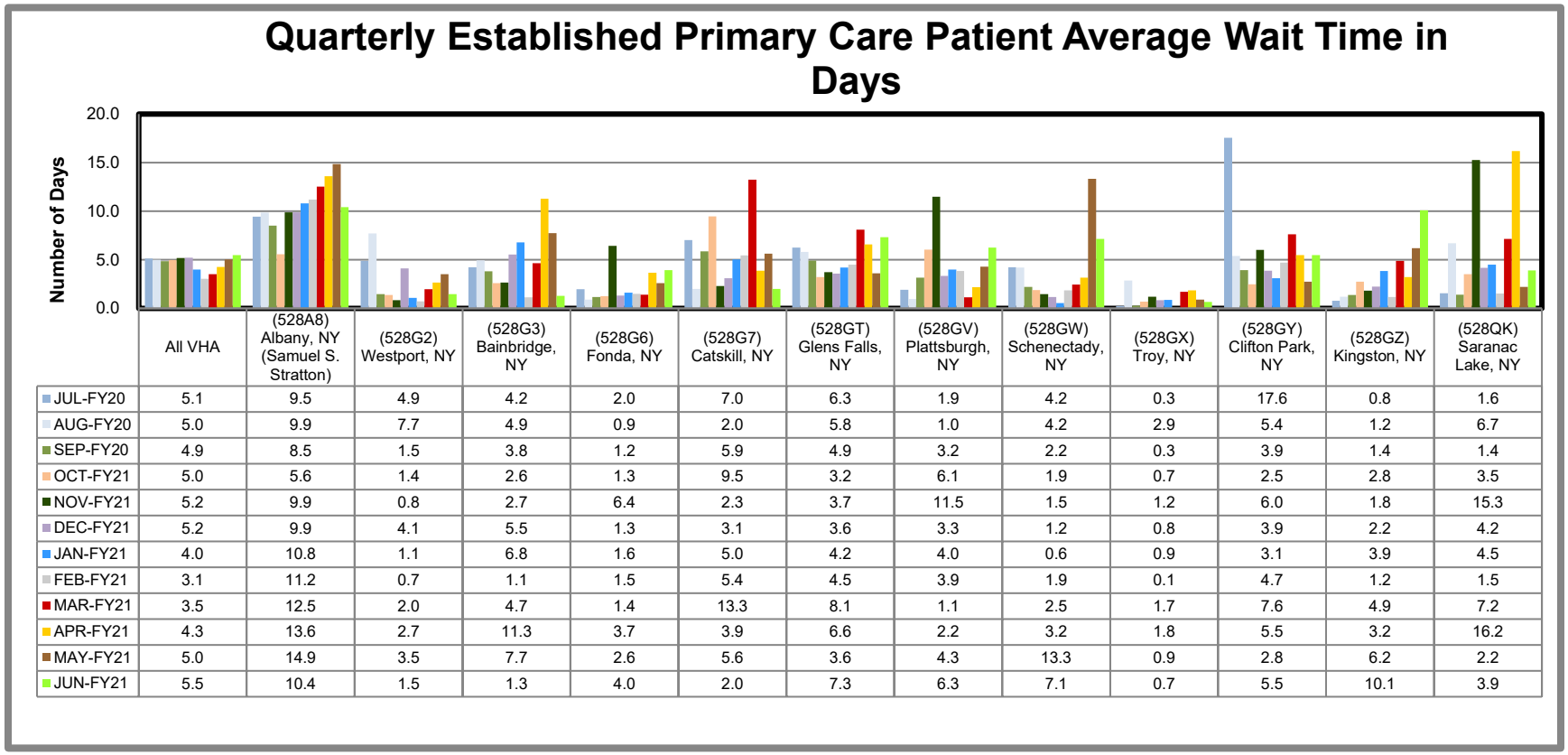


	All VHA	(528A8) Albany, NY (Samuel S. Stratton)	(528G2) Westport, NY	(528G3) Bainbridge, NY	(528G6) Fonda, NY	(528G7) Catskill, NY	(528GT) Glens Falls, NY	(528GV) Plattsburgh, NY	(528GW) Schenectady, NY	(528GX) Troy, NY	(528GY) Clifton Park, NY	(528GZ) Kingston, NY	(528QK) Saranac Lake, NY
JUL-FY20	5.9	26.5	0.0	17.5	13.0	0.0	0.3	0.0	4.3	0.0	n/a	1.7	0.0
AUG-FY20	5.6	19.3	0.0	n/a	10.0	0.0	3.8	0.0	0.4	n/a	0.0	0.0	n/a
SEP-FY20	6.1	11.8	0.0	0.0	3.3	0.0	6.3	1.8	0.2	5.3	0.0	0.7	17.2
OCT-FY21	6.3	7.2	0.0	0.0	1.4	9.8	3.2	3.1	0.0	5.0	2.2	0.0	0.0
NOV-FY21	6.7	13.7	0.0	0.0	2.5	21.3	1.4	3.2	6.3	12.8	0.6	0.0	1.3
DEC-FY21	6.6	15.0	1.3	1.2	0.0	14.0	0.0	8.0	1.2	9.4	0.0	2.5	14.9
JAN-FY21	4.4	8.9	0.0	0.0	4.0	n/a	1.1	0.0	0.4	0.0	2.0	2.7	40.9
FEB-FY21	2.9	11.8	3.5	0.0	2.0	0.0	5.3	0.0	3.0	8.0	0.0	1.1	4.3
MAR-FY21	2.9	16.7	0.0	6.1	3.5	10.7	2.4	1.5	11.0	16.9	2.0	4.4	0.0
APR-FY21	4.0	20.7	0.0	1.4	2.5	25.0	4.3	1.0	3.8	4.1	19.3	1.9	23.3
MAY-FY21	5.8	45.6	7.0	0.0	6.7	6.5	9.4	1.0	12.3	0.0	0.0	4.3	10.0
JUN-FY21	6.3	22.5	n/a	0.0	5.8	n/a	1.7	0.1	2.8	n/a	5.3	1.7	6.0

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the medical center's explanation for the increased wait times for the Albany clinic and Saranac Lake community-based outpatient clinic.

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."



	All VHA	(528A8) Albany, NY (Samuel S. Stratton)	(528G2) Westport, NY	(528G3) Bainbridge, NY	(528G6) Fonda, NY	(528G7) Catskill, NY	(528GT) Glens Falls, NY	(528GV) Plattsburgh, NY	(528GW) Schenectady, NY	(528GX) Troy, NY	(528GY) Clifton Park, NY	(528GZ) Kingston, NY	(528QK) Saranac Lake, NY
JUL-FY20	5.1	9.5	4.9	4.2	2.0	7.0	6.3	1.9	4.2	0.3	17.6	0.8	1.6
AUG-FY20	5.0	9.9	7.7	4.9	0.9	2.0	5.8	1.0	4.2	2.9	5.4	1.2	6.7
SEP-FY20	4.9	8.5	1.5	3.8	1.2	5.9	4.9	3.2	2.2	0.3	3.9	1.4	1.4
OCT-FY21	5.0	5.6	1.4	2.6	1.3	9.5	3.2	6.1	1.9	0.7	2.5	2.8	3.5
NOV-FY21	5.2	9.9	0.8	2.7	6.4	2.3	3.7	11.5	1.5	1.2	6.0	1.8	15.3
DEC-FY21	5.2	9.9	4.1	5.5	1.3	3.1	3.6	3.3	1.2	0.8	3.9	2.2	4.2
JAN-FY21	4.0	10.8	1.1	6.8	1.6	5.0	4.2	4.0	0.6	0.9	3.1	3.9	4.5
FEB-FY21	3.1	11.2	0.7	1.1	1.5	5.4	4.5	3.9	1.9	0.1	4.7	1.2	1.5
MAR-FY21	3.5	12.5	2.0	4.7	1.4	13.3	8.1	1.1	2.5	1.7	7.6	4.9	7.2
APR-FY21	4.3	13.6	2.7	11.3	3.7	3.9	6.6	2.2	3.2	1.8	5.5	3.2	16.2
MAY-FY21	5.0	14.9	3.5	7.7	2.6	5.6	3.6	4.3	13.3	0.9	2.8	6.2	2.2
JUN-FY21	5.5	10.4	1.5	1.3	4.0	2.0	7.3	6.3	7.1	0.7	5.5	10.1	3.9

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

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

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

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES data use engmt	Sharing and use of All Employee Survey (AES) data	A higher value is better than a lower value
Behavioral health (BH90)	Healthcare Effectiveness Data and Information Set (HEDIS) outpatient performance measure composite related to screening for depression, posttraumatic stress disorder, alcohol misuse, and suicide risk	A higher value is better than a lower value
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	Patient-Centered Medical Home (PCMH) Care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care, and information (PCMH survey access composite)	A higher value is better than a lower value
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value
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 18, 2022

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

Subj: Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York

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

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

Thank you for the opportunity to review the OIG draft report, Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York. I concur with the report findings, recommendations and corrective action plans submitted.

(Original signed by:)

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

Appendix H: Executive Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: March 16, 2022

From: Executive Medical Center Director, Samuel S. Stratton VA Medical Center (528A8/00)

Subj: Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York

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

I concur with the recommendations listed in the Office of Inspector General's report, Comprehensive Healthcare Inspection Program of the Samuel S. Stratton VA Medical Center Albany, New York.

(Original signed by:)

Darlene Delancey, MS
Executive Medical Center Director

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