DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA New Jersey Health Care System in East Orange

CHIP REPORT **REPORT #21-00296-145** **MAY 5, 2022**

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Figure 1. *VA New Jersey Health Care System in East Orange.*

Source: https://www.va.gov/new-jersey-health-care/locations/east-orange-va-medical-center/ (*accessed March 31, 2022*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
ECMS	Executive Committee of the Medical Staff
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
PRC	Peer Review Committee
QLC	Quality Leadership Council
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
VANJHCS	VA New Jersey Health Care System
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA New Jersey Health Care System, which includes the East Orange and Lyons VA Medical Centers, and multiple outpatient clinics in New Jersey. 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, also focused on the following additional seven areas:

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

The OIG conducted an unannounced virtual inspection of the VA New Jersey Health Care System during the week of June 28, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help this healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

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[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)."

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued eight recommendations to the 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 healthcare system's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, and two Associate Directors (one for each medical center, East Orange and Lyons). The Chief of Staff and Associate Director for Patient Care Services oversaw patient care, which required managing service directors and chiefs of programs. The Director served as the chairperson of the Quality Leadership Council, which oversaw performance measures; quality improvement activities; and other related programs, committees, and initiatives.

When the OIG team conducted this inspection, the Director had served in the role since 2017, multiple team members had been in their positions for more than a year, and one of the associate director positions was vacant due to retirement.

The OIG noted a budget increase of approximately 9 percent in fiscal year 2020 as compared to the previous year. The Director indicated that many staff retired after the COVID-19 pandemic started and leaders used the additional funds to hire new staff.

Selected employee satisfaction survey scores for the Director and Chief of staff generally trended higher than corresponding VHA scores. However, the scores also revealed opportunities for the Associate Director for Patient Care Services and Associate Director to improve employees' perceptions toward the leaders and workplace. Overall, patient experience survey results indicated that males were generally satisfied with their primary care compared to VHA patients nationally but less pleased with their inpatient and specialty care. There were no inpatient survey data available for female respondents, but their outpatient survey scores were lower than VHA averages.

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."[2]

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[2] "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.)

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[3] In individual interviews, the executive leadership team members with administrative and operational responsibility for the selected metrics were able to speak about actions taken during the previous 12 months to improve or sustain performance.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The healthcare system complied with requirements for a committee responsible for quality, safety, and value oversight functions. However, the OIG identified significant weaknesses in the Systems Redesign and Improvement Program, protected peer reviews, and surgical work group processes.[5]

Registered Nurse Credentialing

The OIG found that registered nurses hired from July 1, 2020, through May 26, 2021, were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with the primary source verification process.

Medication Management

The OIG team observed compliance with many elements of expected performance, including the availability of staff to receive remdesivir shipments, proper naming of medication orders, staff determination that patients met criteria for receiving the medication, and completion of required testing prior to remdesivir administration. However, the OIG identified opportunities for providers to improve their patient and caregiver education.

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

[4] 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.

[5] 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.

Care Coordination

The OIG observed general compliance with requirements for many of the expectations for inter-facility patient transfers. However, the OIG identified concerns with staff monitoring and evaluating the transfers.

High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified opportunities for Disruptive Behavior Committee members to improve meeting attendance.

Conclusion

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

VA Comments

The Veterans Integrated Service Network Director and Acting Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 65–66, 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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Purpose and Scope

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

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

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

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

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[5]
3. Quality, safety, and value
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. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
7. Care coordination (spotlighting inter-facility transfers)
8. High-risk processes (examining the management of disruptive and violent behavior)

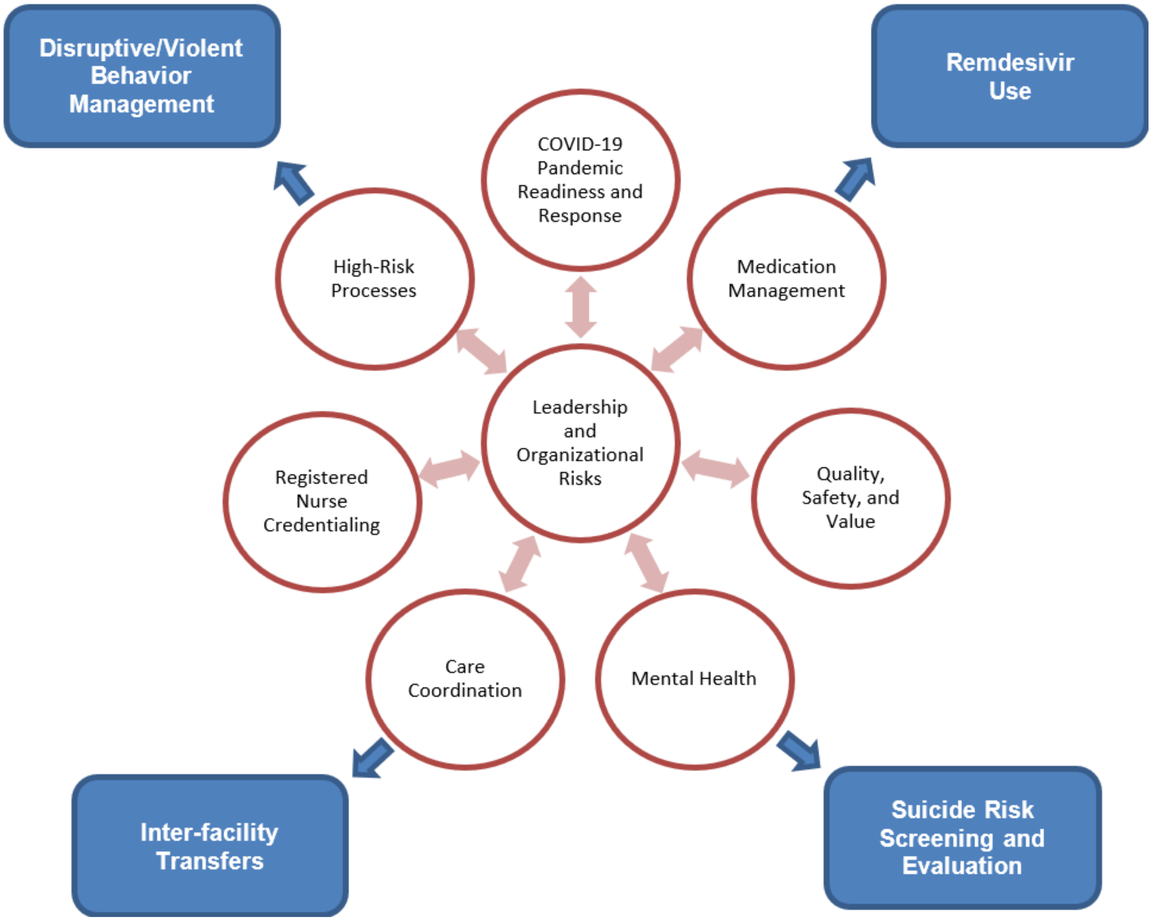
Disruptive/Violent Behavior Management
Remdesivir Use
COVID-19 Pandemic Readiness and Response
High-Risk Processes
Medication Management
Leadership and Organizational Risks
Registered Nurse Credentialing
Quality, Safety, and Value
Care Coordination
Mental Health
Inter-facility Transfers
Suicide Risk Screening and Evaluation

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

Source: VA OIG.

Methodology

The VA New Jersey Health Care System includes the East Orange and Lyons VA Medical Centers and multiple outpatient clinics in New Jersey. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from September 1, 2018, through July 2, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[8]

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

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

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

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

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

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

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

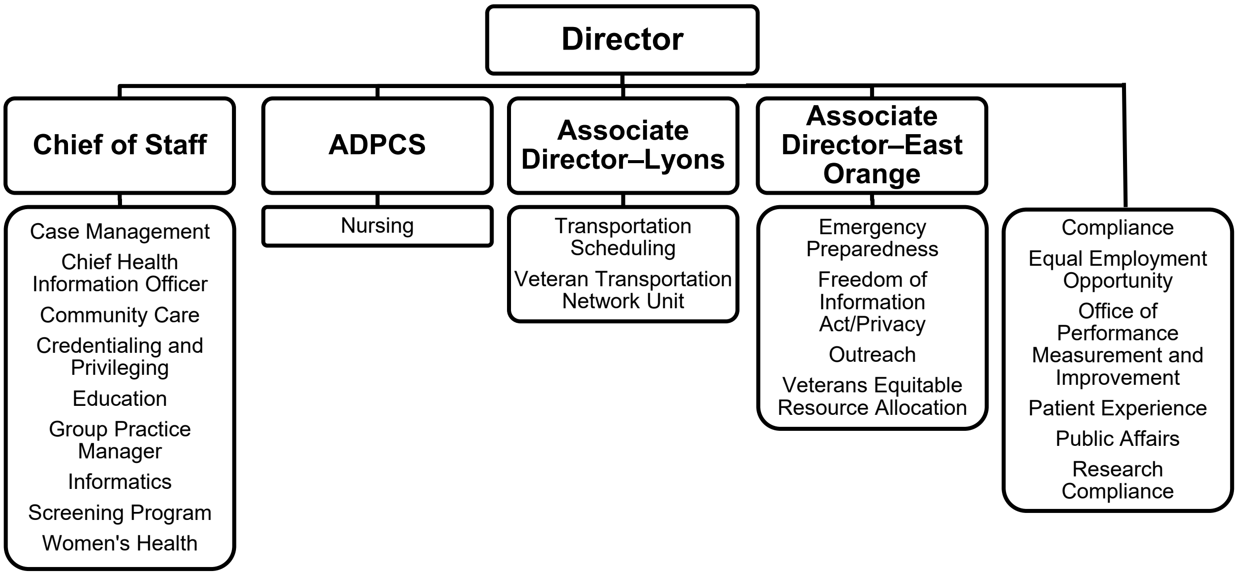
Director
Chief of Staff
ADPCS
Associate Director–Lyons
Associate Director–East Orange
Case Management
Chief Health Information Officer
Community Care
Credentialing and Privileging
Education
Group Practice Manager
Informatics
Screening Program
Women's Health
Nursing
Transportation Scheduling
Veteran Transportation Network Unit
Emergency Preparedness
Freedom of Information Act/Privacy
Outreach
Veterans Equitable Resource Allocation
Compliance
Equal Employment Opportunity
Office of Performance Measurement and Improvement
Patient Experience
Public Affairs
Research Compliance

Figure 3. *Healthcare system organizational chart.*

Source: VA New Jersey Health Care System (received June 28, 2021).

At the time of the OIG inspection, the Director had served in the role since 2017, the Chief of Staff was appointed in 2019, and the ADPCS had been in the position since 1989. The executive team also included two newly appointed acting Associate Directors. The Associate Director for the Lyons VA Medical Center was appointed on March 24, 2013, and then detailed to the same position at the East Orange VA Medical Center on June 25, 2021, after the previous Associate Director retired. Subsequently, the Chief of Environmental Management Service was detailed as the acting Associate Director at the Lyons VA Medical Center (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	January 18, 2017
Chief of Staff	July 21, 2019
Associate Director for Patient Care Services	May 7, 1989
Associate Director–East Orange	June 25, 2021 (acting)
Associate Director–Lyons	June 28, 2021 (acting)

Source: VA New Jersey Health Care System Assistant Human Resources Office/Senior Strategic Business Partner (received June 29, 2021).

The Director served as the chairperson of the Quality Leadership Council, which oversaw performance measures; quality improvement activities; and related programs, committees, and initiatives (see figure 4).

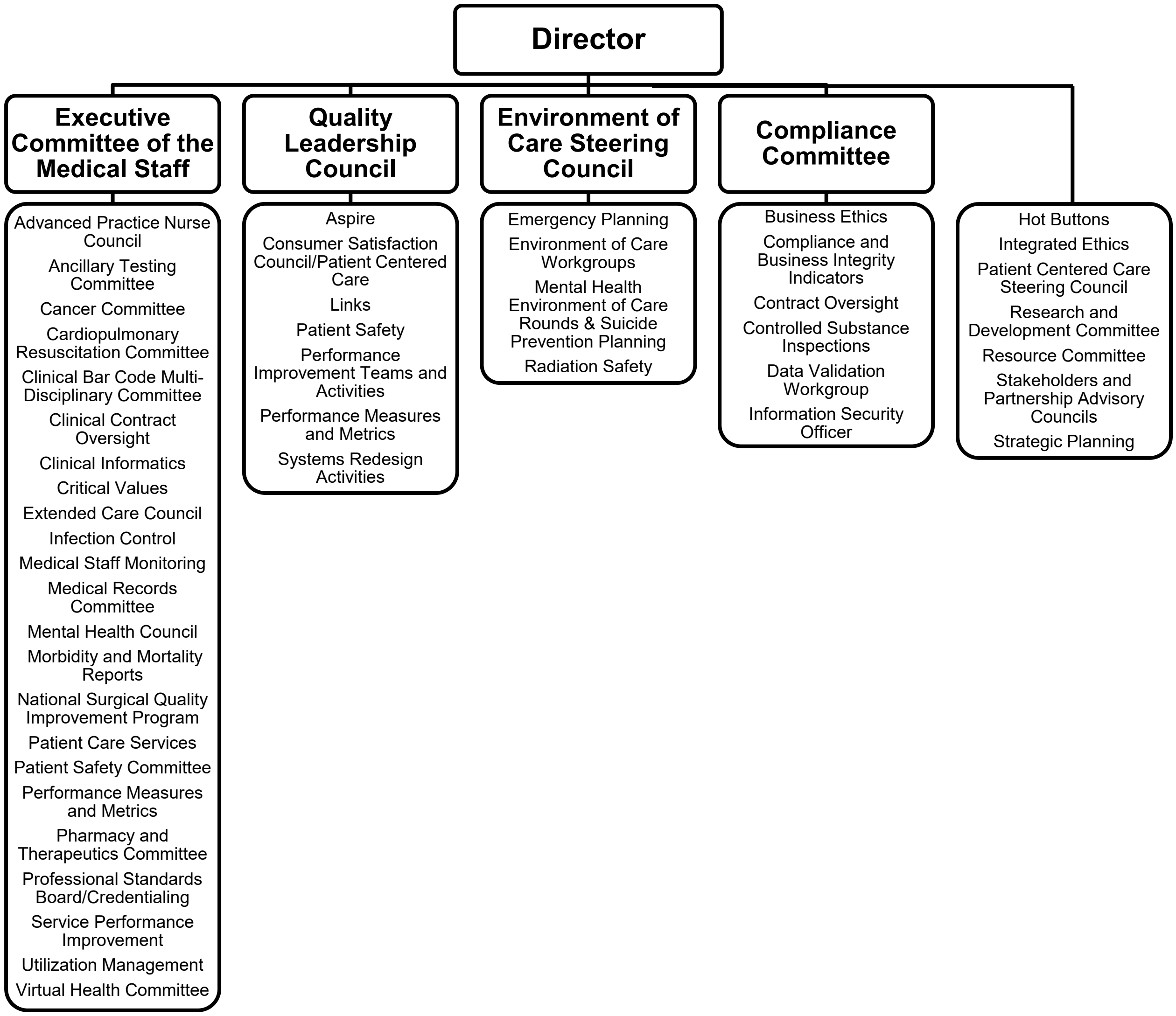
Director
Executive Committee of the Medical Staff
Quality Leadership Council
Environment of Care Steering Council
Compliance Committee
Advanced Practice Nurse Council
Ancillary Testing Committee
Cancer Committee
Cardiopulmonary Resuscitation Committee
Clinical Bar Code Multi-Disciplinary Committee
Clinical Contract Oversight
Clinical Informatics
Critical Values
Extended Care Council
Infection Control
Medical Staff Monitoring
Medical Records Committee
Mental Health Council
Morbidity and Mortality Reports
National Surgical Quality Improvement Program
Patient Care Services
Patient Safety Committee
Performance Measures and Metrics
Pharmacy and Therapeutics Committee
Professional Standards Board/Credentialing
Service Performance Improvement
Utilization Management
Virtual Health Committee
Aspire
Consumer Satisfaction Council/Patient Centered Care
Links
Patient Safety
Performance Improvement Teams and Activities
Performance Measures and Metrics
Systems Redesign Activities
Emergency Planning
Environment of Care Workgroups
Mental Health Environment of Care Rounds & Suicide Prevention Planning
Radiation Safety
Business Ethics
Compliance and Business Integrity Indicators
Contract Oversight
Controlled Substance Inspections
Data Validation Workgroup
Information Security Officer
Hot Buttons
Integrated Ethics
Patient Centered Care Steering Council
Research and Development Committee
Resource Committee
Stakeholders and Partnership Advisory Councils
Strategic Planning

Figure 4. *Healthcare system committee reporting structure.*

Source: VA New Jersey Health Care System (received June 28, 2021).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPCS, and acting Associate Directors regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the executive leaders with administrative and operational responsibility for the selected metrics were able to speak 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 healthcare system's fiscal year (FY) 2020 annual medical care budget of $624,632,350 increased approximately 9 percent compared to the previous year's budget of $575,230,229.[12] When asked about the effect of this change on the healthcare system's operations, the Director indicated that many staff retired after the COVID-19 pandemic began, and leaders used the additional funds to hire new staff.

Staffing

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

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[16] The Director confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection, except for the dermatology and boiler plant operator positions. The Director explained that leaders collaborated with affiliated institutions to fill physician positions, increased salaries to become more competitive with the private sector, and used contractors and community providers to supplement care delivery.

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[12] VHA Support Service Center.

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

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

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

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

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Pathology Technician/Histopathology	1. General Engineering
2. Rehabilitation Therapy Assistant/Occupation Therapy Assistant	2. Wastewater Treatment Plant Operator
3. Otolaryngology	3. Boiler Plant Operator
4. Psychiatry	4. Fire Protection and Prevention
5. Dermatology	5. Police

Source: VA OIG.

Employee Satisfaction

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

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[19] Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. The OIG found the healthcare system averages for the selected survey leadership questions were lower than VHA averages.[20] The same trend was noted for the ADPCS and Associate Director averages; however, scores related to the Director and Chief of Staff were consistently higher than those for VHA and the healthcare system.[21]

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

[18] "AES Survey History."

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

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

[21] All Employee Survey results are reflective of employee satisfaction for the Associate Director at the East Orange campus. These results are not reflective of the acting Lyons Associate Director, who assumed the role after the survey was administered.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	71.0	81.1	83.4	69.3	67.2
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	3.4	4.0	3.6	3.3	3.3
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	4.2	3.9	3.4	3.4
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.6	3.9	3.8	3.6	3.6

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

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[22] The healthcare system averages for the selected survey questions were slightly less favorable than VHA averages. Scores related to the Director and Chief of Staff were consistently better than those for VHA and the healthcare system. However, survey results revealed opportunities for the ADPCS and Associate Director to improve employees' perceptions of the workplace.

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[22] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, and Associate Directors.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	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	3.7	4.4	4.5	3.6	3.6
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	4.0	3.9	3.6	3.6
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	1.5	1.1	1.0	1.6	1.6

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

VHA leaders have articulated that the agency “is committed to a harassment-free health care environment.”[23] To this end, leaders initiated the “End Harassment” and “Stand Up to Stop Harassment Now!” campaigns to help create a culture of safety where staff and patients feel secure and respected.[24]

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[23] “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.

[24] “Stand Up to Stop Harassment Now!”

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The Director and Chief of Staff averages for the selected survey questions were higher than VHA averages; however, averages for the ADPCS and Associate Director were lower.[25] The Director reported a policy of nontolerance for discrimination in the workplace. The Director also stated that VA's National Center for Organization Development evaluated the system's executive leader's engagement and actions were taken to address the identified issues regarding communication and respect.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	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	3.8	4.0	4.0	3.6	3.6
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.0	4.3	4.4	3.8	3.9
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	3.9	3.9	3.6	3.5

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

Patient Experience

To assess patient experiences with the healthcare system, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through September 30, 2020. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of

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[25] All Employee Survey results are reflective of employee satisfaction for the Associate Director at the East Orange campus. These results are not reflective of the acting Lyons Associate Director, who assumed the role after the survey was administered.

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 healthcare system.[26] With the exception of the Patient-Centered Medical Home score, the overall patient satisfaction survey results reflected lower care ratings than VHA averages. The Director attributed the suboptimal scores to staff's poor communication with patients and reported implementing rounds to proactively ensure improved engagement with veterans.

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

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	56.4
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	85.3
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	83.0

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

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

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

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys (see tables 7–9). Male respondents rated their primary care experiences more favorably than corresponding VHA averages. However, results suggested they were less pleased with their inpatient and specialty care experiences. There were no inpatient survey data available for female respondents due to low response numbers; however, they rated their outpatient experiences lower compared to VHA patients nationally. Executive leaders appeared to be actively engaged with male and female patients (for example, by educating nurses on being courteous and respectful and facilitating a work group of women veterans to hear concerns and suggestions for improvement). The Director acknowledged opportunities for improvement in specialty care and reported challenges recruiting some specialists because of salary competition.

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

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

Questions	Scoring	VHA*		Healthcare System[†]	
		Male Average	Female Average	Male Average	Female Average[‡]
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	58.2	–
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	85.2	–
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	84.6	–

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

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

[†] *The healthcare system averages are based on 342–346 male respondents, depending on the question.*

[‡] *Data were not available due to the small number of female respondents.*

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

Questions	**Scoring**	**VHA***		**Healthcare System†**	
		Male Average	**Female Average**	**Male Average**	**Female Average**
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	57.4	32.1
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	61.8	43.0
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	79.7	64.9

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 healthcare system averages are based on 712–2,502 male and 33–73 female respondents, depending on the question.*

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

Questions	**Scoring**	**VHA***		**Healthcare System†**	
		Male Average	**Female Average**	**Male Average**	**Female Average**
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	45.1	39.1
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	57.7	48.5
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	72.2	65.8

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

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

† The healthcare system averages are based on 413–1,121 male and 18–43 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.[28] Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint

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

Commission (TJC).[29] At the time of the OIG inspection, system leaders had closed all recommendations for improvement issued since the previous CHIP site visit conducted in August 2018. The OIG noted that the system had 60 open TJC recommendations but the survey was performed in May 2021, approximately one month prior to the OIG inspection.

The OIG team also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities.[30] Additional results included the Long Term Care Institute's inspection of the CLCs and the Paralyzed Veterans of America's inspection of the spinal cord injury/disease unit and related services.[31]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the VA New Jersey Health Care System, East Orange, New Jersey*, Report No. 18-01164-42, December 27, 2018)	August 2018	6	0
TJC Opioid Treatment Program	February 2021	5	0
TJC Hospital Accreditation TJC Behavioral Health Care Accreditation TJC Home Care Accreditation	May 2021	45 8 2	45 8 2
TJC Home Care Laboratory	May 2021	5	5

Source: OIG and TJC (inspection/survey results received from the Deputy Quality Manager/Lead Accreditation Specialist and Quality Management Specialist, Accreditation on June 28, 2021).

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[29] 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."

[30] 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."

[31] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings." The Paralyzed Veterans of America inspection took place February 13, 2020. This veterans service organization review does not result in accreditation status.

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

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

Table 11 lists the reported patient safety events from September 1, 2018 (the prior OIG CHIP site visit), through June 28, 2021.[32]

Table 11. Summary of Selected Organizational Risk Factors (September 1, 2018, through June 28, 2021)

Factor	Number of Occurrences
Sentinel Events	18
Institutional Disclosures	5
Large-Scale Disclosures	0

Source: VA New Jersey Health Care System's Risk Manager and Patient Safety Officers (received June 28 and July 23, 2021).

The Director spoke knowledgeably about serious adverse event reporting. The Director stated that staff report all adverse events either during the daily morning conference with executive leaders or directly to the Chief of Staff and Director of Quality Management, who both have an open-door policy. The Director explained that after events are reviewed, institutional disclosure determinations are made in collaboration with the Chief of Staff and Director of Quality

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

Management. The Risk and Patient Safety Managers added that leaders conducted a root cause analysis or institutional disclosure for each sentinel event.

Veterans Health Administration Performance Data for the Healthcare System

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

Figure 5 illustrates the healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the system's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, health care (HC) associated (assoc) infections, mental health (MH) continuity (of) care, and stress discussed). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, emergency department (ED) throughput, adjusted length of stay (LOS), and rating (of) specialty care (SC) provider).[35]

Leaders spoke knowledgeably about actions taken to improve poorly performing SAIL measures. For example, the Director reported implementing interdisciplinary discharge planning rounds and establishing subacute beds to improve the adjusted LOS measure.

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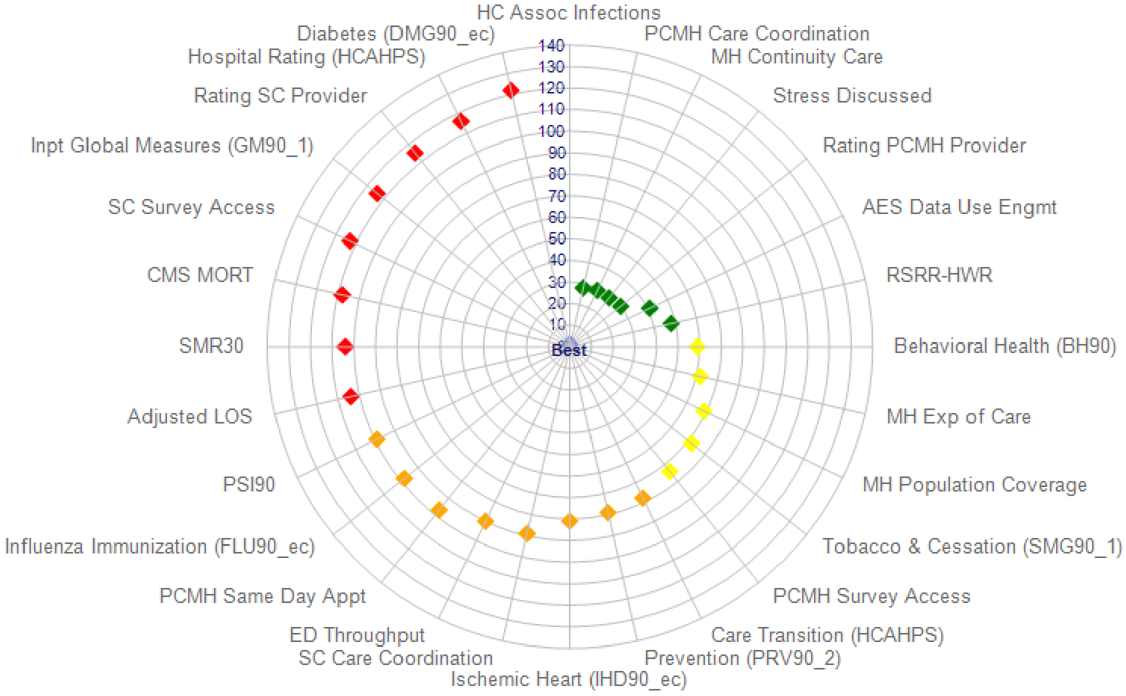
[33] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020, https://vssc.med.va.gov. (This is an internal website not publicly accessible.)

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

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

Source: VHA Support Service Center.

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

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."[36] 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."[37]

Figures 6 illustrates the system'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

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[36] 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.

[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*. "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."

(blue and green data points) in the first and second quintiles (for example, physical restraints–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and urinary tract infection (UTI) (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, outpatient ED visit (SS) and discharged to community (SS)).[38]

Leaders spoke in depth about actions taken to improve CLC performance. The Director stated that staff monitor each resident who goes from the CLC to the emergency department and determine reasons for the transfers and how care can be improved to avoid these situations in the future. The Director also reported that social workers and the care team have interdisciplinary meetings with the resident to plan a safe discharge. Additionally, the Director discussed implementing watch-list huddles where team members can raise concerns and report any changes in a resident's condition.

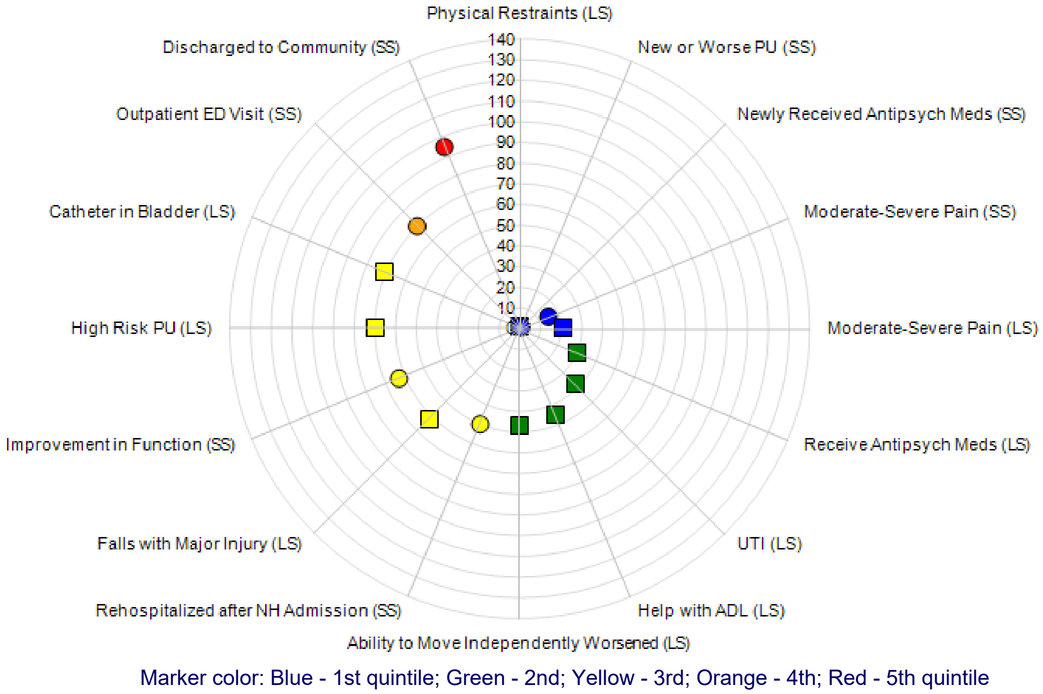

Figure 6. *Lyons CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).*

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 healthcare system's Director, Chief of Staff, and ADPCS were appointed in 2017, 2019, and 1989, respectively. The Associate Directors were serving in acting capacities at the time of the

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

OIG inspection. The Director served as the chairperson of the Quality Leadership Council, which oversaw performance measures; quality improvement activities; and related programs, committees, and initiatives.

The healthcare system's FY 2020 annual medical care budget increased approximately 9 percent compared to the previous year, and executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Selected employee satisfaction survey responses revealed opportunities for the ADPCS and Associate Director to improve employees' perceptions toward the leaders and workplace. The Director and Chief of Staff's scores generally trended higher than VHA averages.

Patient experience survey results indicated that males were generally satisfied with the primary care provided compared to VHA patients nationally; however, results suggested they were less pleased with their inpatient and specialty care experiences. There were no inpatient survey data available for female respondents, but they rated their outpatient experiences lower than female patients across VHA.

The OIG's review of the system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. In addition, the executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the “alarming levels of spread and severity” of COVID-19, the World Health Organization declared a pandemic.[39] 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.[40]

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.”[41] “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.”[42]

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

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

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

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[39] “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.

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

[41] 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.”

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

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[43]

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[43] 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.[44] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[45] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[46]

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

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

The OIG reviewers also assessed the healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[47] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[48] The OIG team examined various requirements related to systems redesign and improvement:

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

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

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

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

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

[48] VHA Directive 1026.01.

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[49] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[50] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[51] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[52]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[53]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the healthcare system's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[54] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[55] The healthcare system's performance was assessed on several dimensions:

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

[50] VHA Directive 1190.

[51] VHA Directive 1190.

[52] VHA Directive 1190.

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

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

- 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[56]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[57]

Quality, Safety, and Value Findings and Recommendations

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

VHA requires a systems redesign and improvement coordinator to participate on the "Facility Quality Management Committee to review: improvement needs, data, business rules, and to ensure that key improvement, quality, safety, and value functions are discussed and integrated on a regular basis."[58] The OIG reviewed the Quality Leadership Council meeting minutes from September 29, 2020, through April 19, 2021, and found that the Systems Redesign Coordinator participated in only 1 of 8 meetings (13 percent).[59] The lack of participation could hinder leaders' oversight and result in missed opportunities for them to identify improvement needs. The Director of Quality Management reported being aware of the requirement and attributed the noncompliance to the systems redesign coordinator position being vacant from December 31, 2019, until March 14, 2021.

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

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

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

[58] VHA Directive 1026.01.

[59] The Quality Leadership Council did not meet in June and July 2020, or May and June 2021; therefore, there were eight meetings held during the review period.

Recommendation 1

1. The Director evaluates and determines any additional reasons for noncompliance and ensures the Systems Redesign Coordinator participates on the Quality Leadership Council.

Healthcare system concurred.

Target date for completion: May 31, 2022

Healthcare system response: The Director evaluated and determined no additional reasons for noncompliance. The Director concurs that at the time of the OIG CHIP review, the healthcare system's System Redesign Coordinator had only participated in one of the eight Quality Leadership Council (QLC) meetings due to the position vacancy from December 31, 2019, through March 14, 2021. The Director has initiated a corrective action plan which includes the following:

- Two System Redesign staff members were hired. The first started in late March 2021 and the second started in late April 2021
- Once the System Redesign staff members joined VA New Jersey Health Care System (VANJHCS), they ensured that one always attended the QLC meetings as a voting member and have been present at all meetings since that time.

The Director has fully implemented the corrective actions and VANJHCS [VA New Jersey Health Care System] is in compliance with this recommendation. Adherence is monitored to ensure compliance via the QLC attendance and minutes. The QLC is chaired by the Director.

VHA requires the Peer Review Committee to recommend individual improvement actions and clinical managers to implement the recommendations to ensure the quality of health care delivered.[60] The OIG reviewed documentation for seven Level 3 peer reviews conducted from June 2020 through June 2021 and found that the Peer Review Committee did not recommend improvement actions for two of them.[61] Additionally, the OIG found that clinical managers did not implement improvement actions for one peer review that had recommendations. The failure to recommend and implement actions could prevent improvements in patient safety and healthcare provider practices. The Director of Quality Management attributed noncompliance to a vacancy in the risk manager position from December 2019 through October 2020 and a lack of routine monitoring of the peer review program due to COVID-19 pandemic response activities.

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[60] VHA Directive 1190.

[61] The Peer Review Committee is not reflected in the committee reporting structure (figure 4); however, this committee reports to the Executive Committee of the Medical Staff.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Peer Review Committee recommends individual improvement actions, and clinical managers implement the committee's recommendations.

Healthcare system concurred.

Target date for completion: August 31, 2022

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Chief of Staff (COS) concurs that at the time of the OIG CHIP review, the healthcare system did not complete[ly] implement the required recommendations and improvement actions for three of the seven Level 3 Peer Reviews presented to the Peer Review Committee (PRC) between June 2020 through June 2021. The COS has initiated a corrective action plan which includes the following:

- The Peer Review Committee Charter was completed to formalize the actions and responsibilities of the members and to ensure compliance with VHA Directive 1190. This Charter was published on the VANJHCS Policy/Standard Operating Procedure (SP)/Charter SharePoint in January 2022. This SharePoint provides all VANJHCS employees 24/7 access.
- The Chairperson, Peer Review Committee (PRC), ensures that all Level 3 peer reviews are presented at every meeting, tracked through to closure, and documented in the PRC minutes.
- The Chairperson, Peer Review Committee, also ensures the Clinical Chiefs and Managers implement any improvement actions recommended for Level 3 and present the required data to the PRC.
- The Chairperson, Peer Review Committee, reports quarterly to the Executive Committee of the Medical Staff (ECMS).

The COS anticipates full implementation of the corrective actions by the end of May 2022. Adherence to the revised process will be monitored to ensure compliance and reported at ECMS. The ECMS is chaired by the COS.

VHA requires final peer reviews to be completed within 120 calendar days from the determination that a peer review is needed unless a written extension request is approved by the facility director.[62] From June 2020 through June 2021, the OIG found that staff did not complete 2 of 14 peer reviews (14 percent) within the 120-day timeframe or have a written extension request approved by the Director. This could prevent timely improvements in patient care and safety at the healthcare system. The Director of Quality Management attributed noncompliance to staff's inability to access relevant peer review documentation located in the encrypted files of the former risk manager, who retired in December 2019.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that staff complete final peer reviews within 120 calendar days from the date it is determined a peer review is required or have a written extension request approved by the Director.

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[62] VHA Directive 1190.

Healthcare system concurred.

Target date for completion: August 31, 2022

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Chief of Staff (COS) concurs that at the time of the OIG CHIP review, the healthcare system did not complete the final peer review within 120 calendar days from the determination that a peer review was needed and did not obtain a written extension request signed by the Director. The COS has initiated a corrective action plan which includes the following:

- The Peer Review Committee Charter was completed to formalize the actions and responsibilities of the members and to ensure compliance with VHA Directive 1190. This Charter was published on the VANJHCS Policy/SOP [standard operating procedure]/Charter SharePoint in January 2022. This SharePoint provides all VANJHCS employees 24/7 access.
- The Chairperson, PRC, ensures that all Peer Reviews are presented at every meeting and tracked through to closure.
- Peer Review due dates are noted in the PRC minutes and the Service Chiefs are informed to complete a written extension request signed by the Director prior to the end of the required timeframe, if needed.
- The Chairperson, PRC, provides quarterly report to the Executive Committee of the Medical Staff (ECMS).

The COS anticipates full implementation of the corrective actions by the end of May 2022. Adherence to the revised process will be monitored to ensure compliance and reported at ECMS. The ECMS is chaired by the COS.

VHA requires the Peer Review Committee to submit quarterly summaries of peer review data for review by an executive-level medical committee (locally known as the Executive Committee of the Medical Staff).[63] The OIG found that from July 17, 2020, through May 21, 2021, the Peer Review Committee did not submit quarterly summary reports to the Executive Committee of the Medical Staff. Failure to submit summary reports may prevent executive-level oversight in the identification of clinical practice trends and determination of the effectiveness of quality improvement initiatives and any need for further action. The Director of Quality Management acknowledged a lack of oversight and stated that the risk manager position responsible for the Peer Review Committee responsibilities noted above was vacant from December 2019 through October 2020, and quality management staff could not cover those responsibilities because they had been detailed to provide patient care during the pandemic.

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[63] VHA Directive 1190.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Peer Review Committee submits quarterly summaries of peer review data for review by the Executive Committee of the Medical Staff.

Healthcare system concurred.

Target date for completion: August 31, 2022

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Chief of Staff (COS) concurs that at the time of the OIG CHIP review, the healthcare system's Peer Review Committee did not submit quarterly summary review to ECMS from July 2020 through May 2021. The COS has initiated a corrective action plan which includes the following:

- The Peer Review Committee Charter was completed to formalize the actions and responsibilities of the members and to ensure compliance with VHA Directive 1190. This Charter was published on the VANJHCS Policy/SOP/Charter SharePoint in January 2022. This SharePoint provides all VANJHCS employees 24/7 access.
- The Risk Manager attends the Peer Review Committee meetings
- Summaries of the peer review data are provided to the ECMS for review on a quarterly basis.

The COS anticipates full implementation of the corrective actions by the end of May 2022. Adherence to the revised process will be monitored to ensure compliance and reported at ECMS. The ECMS is chaired by the COS.

VHA requires directors to ensure facilities have a surgical work group that meets monthly; this work group must be chaired by the Chief of Surgery and include the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[64] Based on a review of meeting minutes from July 8, 2020, through June 9, 2021, the OIG found that the Surgical Work Group did not meet during 3 of 12 months (25 percent).[65] Failure to meet monthly may result in a lack of review and analysis of surgery program activities by key staff. The Chief of Staff stated that meetings were cancelled due to lack of attendance.

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[64] VHA Directive 1102.01(2).

[65] The Surgical Work Group is not reflected in the committee reporting structure (figure 4); however, this group reports to the Executive Committee of the Medical Staff.

Recommendation 5

5. The Director evaluates and determines any additional reasons for noncompliance and makes certain that the Surgical Work Group meets at least monthly.

Healthcare system concurred.

Target date for completion: May 31, 2022

Healthcare system response: The Director evaluated and determined no additional reasons for noncompliance. The Director concurs that at the time of the OIG CHIP review, the healthcare system did not have the required members participating on the Surgical Committee. The Director has initiated a corrective action plan which includes the following:

- The Chief of Surgery reviewed the Surgical Committee Charter to ensure it contains the required core committee members, committee meeting frequency, and committee functions. This Charter was published on the VANJHCS Policy/SOP/Charter SharePoint in February 2021. This SharePoint provides all VANJHCS employees 24/7 access.
- The Chairperson of the Surgical Committee is the Chief of Surgery and now ensures that the required core members are present at the start of each meeting.
- Attendance is documented in the monthly committee meetings minutes.
- The Surgical Committee minutes and attendance were provided to the Lead Accreditation Specialist/Deputy QM [Quality Manager] demonstrating over six consecutive months of compliance from August 2021 to the present.

The Chief of Surgery has fully implemented the corrective actions and VANJHCS is in compliance with this recommendation. Adherence is monitored and reported to the Quality Leadership Council. The QLC is chaired by the 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."[66] 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."[67]

VA requires all RNs to hold at least one active, unencumbered license.[68] 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.[69] 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.[70] 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.[71]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 15 RNs hired from July 1, 2020, through May 26, 2021. The OIG determined whether

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

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

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[66] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (This directive 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.)

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

[68] VHA Directive 2012-030. "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."

[69] 38 U.S.C. § 7402.

[70] VHA Directive 2012-030.

[71] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The OIG found that RNs hired from July 1, 2020, through May 26, 2021, were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with the primary source verification process.

VHA requires medical facility directors to ensure that licensed healthcare professionals' credentialing information is verified from primary sources prior to their initial appointment or transfer from another medical facility.[72] The OIG did not find evidence that credentialing staff completed primary source verification for each license held for 2 of 15 RNs prior to their appointment. This could lead to the inappropriate hiring of nurses and subsequently affect the provision of quality care.

For one of the two RNs, the acting Manager for Credentialing and Privileging acknowledged lacking communication with Human Resources and reported that credentialing staff were unaware that the RN was employed at the facility until five months after the appointment. For the second RN, the acting Manager for Credentialing and Privileging reported that credentialing staff did not consistently use the National Council of State Boards of Nursing data repository, and consequently, were unaware of the RN's second license until the OIG's virtual inspection.[73]

Recommendation 6

6. The Director evaluates and determines any additional reasons for noncompliance and ensures credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.

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[72] VHA Directive 2012-030.

[73] "Welcome to Nursys," National Council of State Boards of Nursing, accessed March 3, 2022, https://www.nursys.com. "Nursys.com provides online verification for endorsement to a nurse requesting to practice in another state and anyone who wants to verify a nurse license."

Healthcare system concurred.

Target date for completion: May 31, 2022

Healthcare system response: The Director evaluated and determined no additional reasons for noncompliance. The Director concurs that at the time of the OIG CHIP review, the healthcare system did not have evidence of Registered Nurses' (RN) primary source verification for two of the fifteen new RNs reviewed. The Director has initiated a corrective action plan which includes the following:

- The Credentialing & Privileging (C&P) Managers revised their process to ensure that all new RNs have a completed primary source verification which includes a review via the National Council of State Boards of Nursing data repository known as Nursys.
- The primacy source verification is uploaded into Vet Pro prior to the RN's appointment and the Service Chief reviews.
- The C&P Managers continue to utilize the monitor provided by the OIG CHIP Survey Team to ensure sustained compliance.

The Director has fully implemented the corrective actions and VANJHCS is in compliance with this recommendation. Adherence is monitored and reported to the Quality Leadership Council. The QLC is chaired by the Director.

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[74] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[75]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[76] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[77]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[78] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[79]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of seven patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments
- Medication orders used proper name

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[74] Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*, May 1, 2020, revised August 2020; Food and Drug Administration, "Frequently Asked Questions for Veklury (remdesivir)," updated February 4, 2021.

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

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

[77] Centers for Disease Control and Prevention, *Vaccine Storage and Handling Kit*, May 2014. "The cold chain begins with the cold storage unit at the manufacturing plant, extends through transport of vaccine(s) to the distributor, then delivery and storage at the provider facility, and ends with administration of vaccine to the patient. Appropriate storage conditions must be maintained at every link in the cold chain." Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients.*

[78] Food and Drug Administration, "FDA News Release: COVID-19 Update: FDA Broadens Emergency Use Authorization for Veklury (remdesivir) to Include All Hospitalized Patients for Treatment of COVID-19," August 28, 2020.

[79] Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19," October 22, 2020.

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
    - Potential pregnancy
    - Kidney assessment (estimated glomerular filtration rate)[80]
    - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[81]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG team observed compliance with many indicators of expected performance, including the availability of staff to receive remdesivir shipments, proper naming of medication orders, staff determination that patients met criteria for receiving the medication, and completion of required testing prior to remdesivir administration. However, the OIG identified deficiencies with the provision of patient and caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, inform patients or caregivers that remdesivir was not an FDA-approved medication prior to the administration, provide the option to refuse the medication, and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[82] For the seven patients who received remdesivir, the OIG determined that healthcare providers did not

- provide any of the patients or caregivers with the *Fact Sheet for Patients and Parents/Caregivers*,
- inform 43 percent of patients or caregivers that remdesivir was not an FDA-approved medication,
- inform 71 percent of patients or caregivers of the option to refuse remdesivir, and

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[80] "Estimated Glomerular Filtration Rate (eGFR)," National Kidney Foundation, accessed December 9, 2020, https://www.kidney.org/atoz/content/gfr. "Estimated glomerular filtration rate [eGFR] is the best test to measure your level of kidney function and determine your stage of kidney disease."

[81] "Alanine transferase," National Cancer Institute, accessed December 9, 2020, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/alanine-transferase. Alanine transferase, also referred to as serum glutamate pyruvate transaminase, is "an enzyme found in the liver and other tissues," of which a high level may be indicative of liver damage.

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

- advise 29 percent of patients or caregivers of the risks, benefits, and alternatives to remdesivir prior to administration.

This could have resulted in patients or caregivers lacking the information needed to make a fully informed decision to receive the medication. The Chief of Pharmacy, Medical Director for Critical Care, and Infectious Disease Clinical Pharmacy Specialist indicated that providers discussed the information with patients or caregivers during telephone conversations and they believed this met the requirement. Further, the Infectious Disease Clinical Pharmacy Specialist stated that providers counseled patients but did not document it.

Given the FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.[83]

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[83] Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19."

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[84] 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.[85] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[86]

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 EDs 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.[87] 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.[88] The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

[87] 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.

[88] 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 48 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 OIG found the healthcare system had generally complied with the requirements listed above, and therefore, 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.[89]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients."[90] 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.[91]

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

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

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 29 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with requirements for many of the expectations for inter-facility patient transfers. However, the OIG identified concerns with staff monitoring and evaluating the transfers.

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

[90] VHA Directive 1094.

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

VHA requires the Chief of Staff and ADPCS to ensure that "[a]ll transfers are monitored and evaluated as part of VHA's Quality Management Program."[92] The Chief of Emergency Services informed the OIG that healthcare system staff did not monitor and evaluate patient transfers from June 2020 through May 2021. Failure to monitor and evaluate patient transfers could hinder the healthcare system's ongoing performance improvement activities. The Chief of Emergency Services reported being unaware of the requirement and stated that the ADPCS reported transfer information during the morning report but was unable to provide the OIG with evidence.

Recommendation 7

7. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain all inter-facility transfers are monitored and evaluated as part of the Veterans Health Administration's Quality Management Program.

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[92] VHA Directive 1094.

Healthcare system concurred.

Target date for completion: July 31, 2022

Healthcare system response: The Chief of Staff and Associate Director for Patient Care Services evaluated and determined no additional reasons for noncompliance. The Chief of Staff (COS) and Associate Director for Patient Care Services concur that at the time of the OIG CHIP review, the healthcare system had only an informal process of reporting interfacility transfer every morning at the Management Daily Morning Report and did not have a formal process to monitor and evaluate all interfacility transfers. The Chief of Staff and Associate Director for Patient Care Services have initiated a corrective action plan which includes the following:

- VANJHCS reviewed and revised the organization SOP titled “VANJHCS Interfacility Transfer SOP” to ensure compliance with VHA Directive 1094. This SOP was published on the VANJHCS Policy/SOP/Charter SharePoint in late March 2022. This SharePoint provides all VANJHCS employees 24/7 access.
- The Bed Management System Coordinator initiated an open record review to monitor and evaluate all interfacility transfers effective October 1, 2021.
- This record review data is now regularly reported monthly to the Utilization Management (UM) Committee.
- The UM Committee Chair will include this in the quarterly report to the Executive Committee of the Medical Staff (ECMS).

The Chief of Staff and Associate Director for Patient Care Services anticipate full implementation of the corrective actions by the end of July 2022. Adherence to the revised process will be monitored to ensure compliance and reported at ECMS. The ECMS is chaired by the COS. The Associate Director for Patient Care Services is a member of the ECMS.

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."[93] 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."[94] 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[95]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[96]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[97]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[98]

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

[94] VHA Directive 2012-026.

[95] 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."

[96] 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."

[97] 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."

[98] 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.[99] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[100] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG found the healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified a concern with Disruptive Behavior Committee meeting attendance.[101]

VHA requires that the Chief of Staff and Nurse Executive (ADPCS) establish a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; a patient advocate; and a representative from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and a representative of the Union Safety Committee.[102] The committee or board is responsible for coordinating with clinicians, recommending amendments to the patients' treatment plans that may reduce the patients' risk of violence, collecting and analyzing disruptive patient incidents, identifying system problems, and recommending to the Chief of Staff other actions related to the problem of patient violence.[103]

The OIG reviewed Disruptive Behavior Committee meeting minutes from August 2020 through June 2021 and found that the Prevention and Management of Disruptive Behavior Program representative did not attend any of the eight meetings held, and VA police did not attend two of eight meetings (25 percent). This could result in the committee taking a less comprehensive approach when assessing patients' disruptive behavior and carrying out other responsibilities. The Disruptive Behavior Committee Co-chairperson attributed the lack of attendance to competing priorities and staffing issues.

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

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

[101] The Disruptive Behavior Committee is not reflected in the committee reporting structure (figure 4); however, this committee reports to the Chief of Staff and Quality Leadership Council.

[102] VHA Directive 2010-053.

[103] VHA Directive 2010-053.

Recommendation 8

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

Healthcare system concurred.

Target date for completion: May 31, 2022

Healthcare system response: The Chief of Staff and Associate Director for Patient Care Services evaluated and determined no additional reasons for noncompliance. The Chief of Staff and Associate Director for Patient Care Services concur that at the time of the OIG CHIP review, the healthcare system did not have the required members participating on the Disruptive Behavior Committee. The Chief of Staff and Associate Director for Patient Care Services have initiated a corrective action plan which includes the following:

- The Workplace Violence Prevention Program (WVPP) Coordinator initiated a Disruptive Behavior Committee Charter to formally note the required committee members, committee meeting frequency, and committee functions. This Charter was published on the VANJHCS Policy/SOP/Charter SharePoint in late July 2021. This SharePoint provides all VANJHCS employees 24/7 access.
- The WVPP Coordinator serves as the Disruptive Behavior Committee Chairperson.
- The Chairperson, Disruptive Behavior Committee, documents attendance at the monthly committee meetings and ensures a quorum of the required members are present to start the meeting.
- The Chairperson, Disruptive Behavior Committee, provides quarterly report to the Quality Leadership Council (QLC).

The Chief of Staff and Associate Director for Patient Care Services anticipate full implementation of the corrective actions by the end of May 2022. Adherence to the revised process will be monitored to ensure compliance and reported at Quality Leadership Council. The QLC is chaired by the Director. The Chief of Staff and Associate Director for Patient Care Services are members.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines eight OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and 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 healthcare system response • VHA performance data (healthcare system) • 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 healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• The Peer Review Committee recommends individual improvement actions, and clinical managers implement the committee's recommendations.	• The Systems Redesign Coordinator participates on the Quality Leadership Council. • Staff complete final peer reviews within 120 calendar days from the date it is determined a peer review is required or have a written extension request approved by the Director. • The Peer Review Committee submits quarterly summaries of peer review data for review by the Executive Committee of the Medical Staff. • The Surgical Work Group meets at least monthly.
RN Credentialing	• RN licensure requirements • Primary source verification	• Credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient’s active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• None	• All inter-facility transfers are monitored and evaluated 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	• All required members attend Disruptive Behavior Committee meetings.

Appendix B: Healthcare System Profile

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

Table B.1. Profile for VA New Jersey Health Care System (561) (October 1, 2017, through September 30, 2020)

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
Total medical care budget	$560,283,127	$575,230,229	$624,632,350
Number of: • Unique patients	55,950	55,287	52,638
• Outpatient visits	720,316	733,117	642,481
• Unique employees§	2,535	2,616	2,547
Type and number of operating beds: • Community living center	300	300	300
• Domiciliary	174	168	168
• Medicine	107	39	39
• Mental health	152	66	66
• Neurology	8	1	1
• Residential rehabilitation	12	12	12
• Spinal cord	14	18	18
• Surgery	38	38	38
Average daily census: • Community living center	165	207	174
• Domiciliary	137	143	94
• Medicine	27	29	34
• Mental health	44	47	29
• Neurology	1	1	2

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[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 healthcare system is associated with a medical residency program.

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
• Residential rehabilitation	9	11	9
• Spinal cord	10	12	9
• Surgery	6	4	3

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

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

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Brick, NJ	561BZ	16,299	7,477	Anesthesia Dermatology Endocrinology Eye Gastroenterology General surgery Gynecology Infectious disease Otolaryngology Podiatry Rehab physician Spinal cord injury Urology	Electrocardiogram (EKG) Radiology	Dental Nutrition Pharmacy Social work Weight management

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[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
Hamilton, NJ	561GA	4,317	743	Anesthesia Dermatology Endocrinology	EKG	Nutrition Pharmacy Social work Weight management
Hackensack, NJ	561GD	10,444	4,057	Anesthesia Eye Infectious disease	EKG	Nutrition Pharmacy Social work Weight management
Jersey City, NJ	561GE	2,554	658	Endocrinology	EKG	Nutrition Social work Weight management
Piscataway, NJ	561GF	4,264	556	Endocrinology	EKG	Nutrition Social work Weight management
Morristown, NJ	561GH	2,948	399	Endocrinology	EKG	Nutrition Social work Weight management
Tinton Falls, NJ	561GI	5,753	2,279	Endocrinology Eye Infectious disease	EKG	Nutrition Pharmacy Social work Weight management

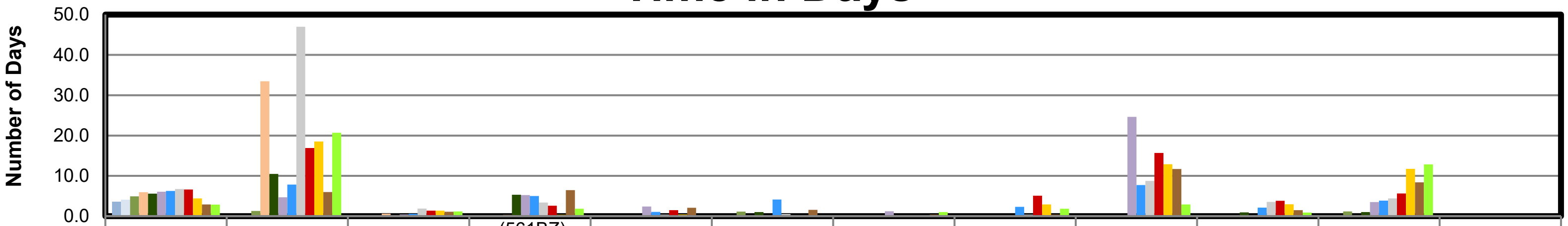
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Paterson, NJ	561GJ	3,069	455	Endocrinology	EKG	Nutrition Social work Weight management
Newton, NJ	561GK	2,233	334	–	EKG	Nutrition Pharmacy Weight management

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (561BY) Newark, NJ, as no data were reported.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days



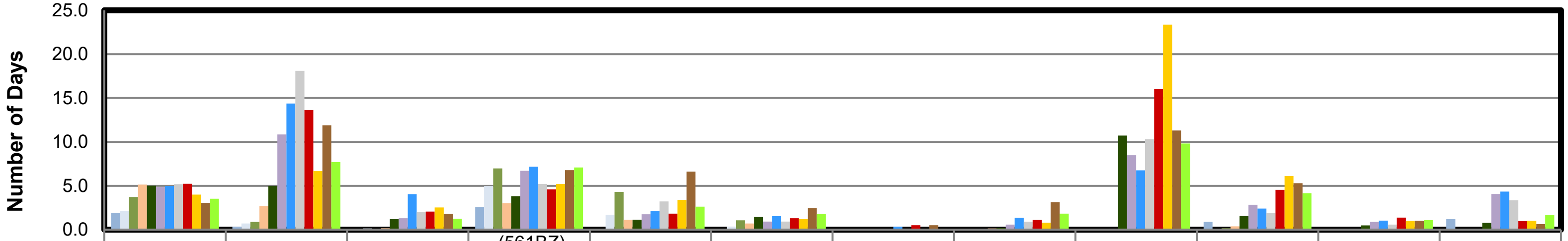
	All VHA	(561) East Orange, NJ	(561A4) Lyons, NJ	(561BZ) Brick, NJ (James J. Howard)	(561GA) Hamilton, NJ	(561GD) Hackensack, NJ	(561GE) Jersey City, NJ	(561GF) Piscataway, NJ	(561GH) Morristown, NJ	(561GI) Tinton Falls, NJ	(561GJ) Paterson, NJ	(561GK) Sussex, NJ
■ APR-FY20	3.6	0.0	0.0	0.0	0.0	n/a	n/a	0.0	n/a	0.0	n/a	n/a
■ MAY-FY20	4.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	n/a	n/a	n/a	n/a
■ JUN-FY20	4.9	1.3	0.2	0.0	0.0	1.1	0.0	0.1	n/a	0.0	1.2	0.0
■ JUL-FY20	5.9	33.5	0.6	0.3	0.0	0.2	0.0	0.0	n/a	0.0	0.0	0.0
■ AUG-FY20	5.6	10.5	0.1	5.3	0.1	1.0	0.1	0.2	0.0	0.9	1.0	0.0
■ SEP-FY20	6.1	4.7	0.4	5.3	2.4	0.1	1.2	0.1	24.6	0.1	3.5	0.0
■ OCT-FY21	6.3	7.8	0.6	5.0	1.0	4.1	0.1	2.3	7.7	2.1	3.8	0.0
■ NOV-FY21	6.7	47.0	1.9	3.4	0.4	0.5	0.2	0.4	8.8	3.5	4.4	0.0
■ DEC-FY21	6.6	16.9	1.4	2.6	1.5	0.0	0.0	5.1	15.7	3.8	5.6	0.0
■ JAN-FY21	4.4	18.5	1.4	0.3	0.4	0.1	0.2	2.9	12.9	2.9	11.8	0.0
■ FEB-FY21	2.9	6.0	1.1	6.4	2.1	1.6	0.4	0.4	11.7	1.5	8.4	0.0
■ MAR-FY21	2.9	20.7	1.2	1.8	0.1	0.2	1.0	1.8	2.9	0.9	12.9	0.0

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (561BY) Newark, NJ, as no data were reported.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	All VHA	(561) East Orange, NJ	(561A4) Lyons, NJ	(561BZ) Brick, NJ (James J. Howard)	(561GA) Hamilton, NJ	(561GD) Hackensack, NJ	(561GE) Jersey City, NJ	(561GF) Piscataway, NJ	(561GH) Morristown, NJ	(561GI) Tinton Falls, NJ	(561GJ) Paterson, NJ	(561GK) Sussex, NJ
■ APR-FY20	1.9	0.3	0.0	2.6	0.1	0.1	0.0	0.0	n/a	0.9	0.1	1.2
■ MAY-FY20	2.1	0.7	0.1	5.0	1.7	0.3	0.0	0.0	0.0	0.0	0.0	0.0
■ JUN-FY20	3.7	0.9	0.1	7.0	4.3	1.1	0.1	0.0	0.0	0.2	0.1	0.0
■ JUL-FY20	5.1	2.7	0.2	3.0	1.1	0.7	0.0	0.2	0.1	0.4	0.0	0.1
■ AUG-FY20	5.0	5.0	1.2	3.8	1.1	1.4	0.0	0.2	10.7	1.6	0.5	0.8
■ SEP-FY20	4.9	10.9	1.3	6.7	1.8	0.9	0.0	0.6	8.5	2.8	0.9	4.1
■ OCT-FY21	5.0	14.4	4.0	7.2	2.2	1.5	0.3	1.3	6.8	2.4	1.0	4.3
■ NOV-FY21	5.2	18.1	2.0	5.2	3.2	0.9	0.1	0.9	10.3	1.9	0.6	3.3
■ DEC-FY21	5.2	13.6	2.1	4.6	1.8	1.3	0.5	1.1	16.0	4.5	1.4	1.0
■ JAN-FY21	4.0	6.7	2.5	5.2	3.4	1.2	0.1	0.8	23.4	6.1	1.0	1.0
■ FEB-FY21	3.1	11.9	1.8	6.8	6.6	2.4	0.5	3.1	11.3	5.3	1.0	0.6
■ MAR-FY21	3.5	7.7	1.2	7.1	2.6	1.8	0.1	1.8	9.8	4.2	1.1	1.6

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (561BY) Newark, NJ, as no data were reported.

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

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

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

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

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

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 22, 2022

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

Subj: Comprehensive Healthcare Inspection of the VA New Jersey Health Care System in East Orange

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

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

Thank you for the opportunity to review the OIG draft report, Comprehensive Healthcare Inspection of the VA New Jersey Health Care System in East Orange, New Jersey. 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: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 21, 2022

From: Director, VA New Jersey Health Care System (561/00)

Subj: Comprehensive Healthcare Inspection of the VA New Jersey Health Care System in East Orange

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

Thank you for the opportunity to review the draft report of the OIG CHIP (Comprehensive Healthcare Inspection Program) Review for our VA New Jersey Health Care System. I have reviewed the document and concur with the recommendations noted.

The VA New Jersey Health Care System has established corrective action plans with designated dates of completion, as detailed in the attached report. If additional information or assistance is needed, please do not hesitate to contact our Lead Accreditation Specialist/Deputy QM.

(Original signed by:)

John A. Griffith
Acting Medical Center Director

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