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VETERANS HEALTH ADMINISTRATION

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

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Figure 1. *Syracuse VA Medical Center in New York.*
Source: https://www.va.gov/syracuse-health-care/locations/syracuse-va-medical-center/ (*accessed February 21, 2023*).

Abbreviations

ADPNS	Associate Director for Patient/Nursing Services
CHIP	Comprehensive Healthcare Inspection Program
EOC	environment of care
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Syracuse VA Medical Center, which includes multiple outpatient clinics in New York. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the Syracuse VA Medical Center during the week of March 13, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued 12 recommendations to the Veterans Integrated Service Network Director, Medical Center Director, Chief of Staff, and Associate Director in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; Environment of Care; and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the

delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A, pages 32–33.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 36–37, 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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Contents

Purpose and Scope

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

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[4]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

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

[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): 13, https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. 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] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Syracuse VA Medical Center includes multiple outpatient clinics in New York. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review the week of March 13, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[5] The OIG's last comprehensive healthcare inspection of the Syracuse VA Medical Center occurred in June 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in October 2021.

[6] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this medical center's leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and medical center leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Medical Center Director (Director), Associate Director, Chief of Staff, and Associate Director for Patient/Nursing Services (ADPNS). The Chief of Staff and ADPNS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the permanent Associate Director, who started in January 2021, had served as the Interim Director since January 2023.[10] The Interim Director stated a facility manager was covering the associate director role. The Chief of Staff, assigned in 2015, had the longest tenure, and the ADPNS, appointed in July 2022, had served in an acting capacity for the prior seven months. The Interim Director described the leaders as a cohesive

[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[8] Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

[10] The prior medical center director left in December 2022.

group who met daily to discuss issues and ensure processes were aligned. The Chief of Staff stated the executive team's transparent approach to communication enabled them to collaboratively solve problems.

To help assess executive leaders' engagement, the OIG interviewed the Interim Director, Chief of Staff, and ADPNS regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $505,129,159 had increased by approximately 7 percent compared to the previous year's budget of $473,121,021.[11] The Interim Director reported spending funds on facility infrastructure, such as updates to the operating room, and on medical and nonmedical equipment. The Interim Director stated leaders used $15 million for nursing contracts to address the personnel shortage and to staff a primary care mental health integration team. The ADPNS stated the COVID-19 pandemic hit the city of Syracuse exceptionally hard, the medical center's 6 to 10 percent nursing vacancy rate had gone as high as 40 percent, and leaders hired contract staff and closed an inpatient unit to mitigate the shortage. The ADPNS added that leaders began a phased reopening of the closed unit in February 2023, since the new VA nursing pay scale had helped with nursing retention and hiring. At the time of the OIG review, the ADPNS said the nursing vacancy rate was 21 percent and reported hiring 16 nurses that week.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[13] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

For FYs 2020 through 2022, the medical center's scores were lower than VHA's. However, the survey results appeared to indicate that staff perceived they could disclose suspected violations. The Interim Director stated that during new employee orientation, staff provide education about

[11] Veterans Health Administration (VHA) Support Service Center.

[12] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

[13] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

the medical center's culture of safety, and during visits to patient care areas, leaders discuss patient safety reporting with staff.[14] The Interim Director described monthly Posting of the Colors ceremonies where leaders recognized staff who reported safety events or close calls with Great Catch awards.[15] The Interim Director added that staff displayed whistleblower posters throughout the facility, employees attended required whistleblower training annually, and supervisors' performance plans included a whistleblower protection objective.[16] The Chief of Staff explained leaders also promoted a culture of safety by emphasizing high-reliability organization principles such as encouraging staff to report mistakes and facilitating a nonpunitive work environment through director's emails, posters throughout the medical center, and postings on the intranet site.[17] The Quality Manager also said the new manager boot camp included culture of safety training.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Syracuse VA Medical Center	3.7	3.8	3.8

Source: VA All Employee Survey (accessed November 15, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

[14] A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

[15] The Posting of the Colors ceremony usually included music, a procession, and raising of the American flag, during which staff received accolades such as time-in-service and Great Catch awards for reporting events that could have resulted in undesirable patient outcomes.

[16] "The Whistleblower Protection Act (WPA), as amended, prohibits retaliation against most federal executive branch employees when they blow the whistle on significant agency wrongdoing or when they engage in protected conduct such as testifying before Congress." Office of the Whistleblower Ombuds, "Whistleblower Protection Act" (fact sheet), accessed May 5, 2023, https://whistleblower.house.gov/sites/whistleblower.house.gov/files/Whistleblower_Protection_Act_Fact_Sheet.pdf.

[17] "An HRO [high-reliability organization] is an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results." Richard A. Stone and Steven L. Lieberman, "VHA's Vision for a High Reliability Organization," *Forum* (Summer 2020), https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm.

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to 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.[18] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

Inpatient survey scores were higher than VHA's, indicating that patients would generally recommend the hospital. The Interim Director stated a committee that evaluates patient experience tracked survey metric drivers such as cleanliness, nighttime noise, and communication. To improve the inpatient experience, the Quality Manager explained that leaders installed a device that alerts staff when noise on a unit increases so they can take measures to reduce it, especially to make nights more peaceful. The Chief of Staff reported reinstating a previously discontinued process in January 2023 in which Environmental Management Services staff who clean rooms also asked patients if they needed anything and provided them with their contact information. In March 2023, the Chief of Staff stated leaders implemented the Commit to Sit program, which calls for providers to pull up a chair and sit when talking with patients to improve communication.

Overall, primary and specialty care survey scores suggested that most respondents were satisfied with the health care they received in the last six months. The OIG noted that primary care scores decreased in FY 2022. The Chief of Staff stated patient fatigue with virtual care used during the pandemic may have decreased patient satisfaction. The leader also explained that although providers began seeing more patients at the facility in FY 2022, staff vacancies made patient access to in-person appointments difficult. To improve patient satisfaction with specialty care, the Chief of Staff reported hiring additional gastroenterology providers and expanding services at clinics to include spinal surgery; ear, nose, and throat; cardiology; chiropractic care; podiatry; acupuncture; and general surgery.

[18] "Patient Experiences Survey Results," VHA Support Service Center.

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	75.2	69.7	73.5	68.9	71.6
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?*†	82.5	88.2	81.9	88.4	81.7	85.6
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	90.3	83.3	86.2	83.1	87.5

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

**The response average is the percent of "Definitely yes" responses.*
†*The response average is the percent of "Very satisfied" and "Satisfied" responses.*

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[19] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[20] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[19] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[20] The Joint Commission, *Standards Manual,* E-dition, January 1, 2022.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[21]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[22] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's 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."[23] Lastly, a large-scale disclosure is "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."[24] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[25]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. The Risk Manager told the OIG that staff can report adverse events and close calls through the Joint Patient Safety Reporting system or to supervisors, patient safety managers, or risk managers.[26] The Patient Safety Manager described hosting monthly patient safety forums, presenting safety stories at town hall meetings, and sharing lessons learned and actions taken at lunch and learns. The Interim Director reported that when adverse events occurred, the manager of the associated clinical area met with the executive team and Risk Manager to review the circumstances; to identify events that happen after hours, patient safety managers reviewed occurrence screens

[21] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

[22] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

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

[24] VHA Directive 1004.08.

[25] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

[26] "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *JPSR Guidebook*, December 2022.

early every weekday and then briefed the executive team in morning reports.[27] The ADPNS stated the executive team also reviewed nursing morning reports, which included all events from the prior 24 hours, and the nurse on duty notified leaders immediately about serious patient safety events that occurred on weekends. The Chief of Staff explained that collectively with the Interim Director, ADPNS, Quality Manager, Risk Manager, and patient safety managers, they reviewed adverse events to determine whether they qualified as sentinel events, and leaders completed institutional disclosures as soon as possible.

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG review, there was an open recommendation from the prior OIG CHIP report.[28] The recommendation was that the Medical Center Director ensures staff complete the required prevention and management of disruptive behavior training. Medical center leaders provided evidence they completed the action plan and requested the recommendation be closed. The OIG closed the recommendation on June 1, 2023.

The OIG made no recommendations.

[27] An occurrence screen is "a review of cases that involve adverse outcomes, such as readmissions or deaths, to identify possible risks to patients." Ronald L. Goldman, Galen L. Barbour, and Eileen Ciesco, "Contribution of Locally and Externally Designed Quality Management Activities to Hospitals' Efforts to Improve Patient Care," *Western Journal of Medicine* 166, no. 2 (February 1997): 110-117, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1304027/.

[28] VA OIG, *Comprehensive Healthcare Inspection of the Syracuse VA Medical Center in New York*, Report No. 21-00294-128, April 19, 2022.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[29] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[30] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[31]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[32] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[33]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[34] 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."[35] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[36]

The OIG team interviewed key managers and staff and reviewed relevant documents. The team also reviewed one Level 3 peer review and nine unexpected deaths that occurred within 24 hours of inpatient admission during FY 2022.[37]

Quality, Safety, and Value Findings and Recommendations

VHA requires the Peer Review Committee to record formal discussions about peer reviews.[38] In addition, VHA requires the medical executive committee to use data "from the Peer Review

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

[30] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[31] VHA Directive 1100.16.

[32] VHA Handbook 1050.01; VHA Directive 1050.01(1).

[33] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[34] 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. VHA Directive 1190.

[35] VHA Directive 1190.

[36] VHA Directive 1190.

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

[38] VHA Directive 1190.

Committee to determine the need for further action" in certain circumstances, such as if there is a trend in the Peer Review Committee reducing the initially assigned peer review level.[39] The OIG determined that Peer Review Committee meeting minutes did not consistently reflect members' rationale when the committee decreased the initial peer reviewer's level of care assignments for physician cases.[40] Further, the OIG found that in Peer Review Committee quarterly reports from FYs 2021 through 2022 (3rd quarter), the committee identified a trend in reduced levels of care for physician cases; however, the Medical Staff Executive Committee minutes lacked discussion of this trend or a need for further action. Peer Review Committee members' failure to document their discussion regarding the rationale for changing the level of care could erode provider and staff confidence in the review process. Moreover, the Medical Staff Executive Committee's lack of discussion of the identified trend may have been a missed opportunity for leaders to improve patient safety. The Chief of Staff, who is the chair of both committees, described physicians as lenient raters and was unable to provide an explanation for why the minutes did not include the rationale for the changes in levels.

Recommendation 1

1. The Chief of Staff ensures staff record the Peer Review Committee's formal discussions related to changes in peer review level assignments in the meeting minutes.

[39] VHA Directive 1190.

[40] "Level 1 is the level at which most experienced and competent clinicians would have managed the case in a similar manner. Level 2 is the level at which most experienced and competent clinicians might have managed the case differently, but it remains within the standard of care." VHA Directive 1190.

Medical center concurred.

Target date for completion: June 30, 2024

Medical center response: Following the OIG CHIP survey, the Chief of Staff worked with the Risk Manager and Quality Management Program Analyst to establish a standard way of capturing and documenting discussions related to changes in peer review level assignments within the Peer Review minutes. The expectation was set that documentation of the discussions related to changes in peer review level assignments needed to be documented for every level. The updated standard was brought to The Peer Review Committee for review and approval in April 2023. Changes in the meeting minutes were also discussed during the May 2023 Medical Service Executive Committee (MSEC) Meeting. Starting with May 2023 Peer Review minutes the Chief of Staff has led a discussion during committee meetings when a level change is proposed up or down. A Quality Management specialist will audit the minutes for compliance. The numerator will represent the total number of level changes with documented discussion leading to the decision to change the level from the initial level. The denominator will represent all changes from the initial level. Compliance of this action will be reported to the Quality Patient Safety Committee (QPS) until compliance of 90 percent or higher is achieved and sustained for six months.

Recommendation 2

2. The Chief of Staff ensures the Medical Staff Executive Committee reviews data provided by the Peer Review Committee to determine the need for further action.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: Following the OIG CHIP survey, the Chief of Staff worked with the Risk Manager to establish a standard of ensuring discussions related to data and trends provided by Peer Review are documented in the MSEC meeting minutes. Peer Review reports quarterly to the MSEC. MSEC reviews the information presented by the Peer Review committee and conducts a discussion to determine if any action is required based on analysis of trends provided. This requirement was outlined and initiated during the May 2023 MSEC meeting. The Chief of Staff has also reviewed all minutes prior to committee approval to ensure documentation of the discussion surrounding peer review data. A Quality Management Specialist will audit MSEC minutes quarterly, assessing for compliance with the above-mentioned documentation requirement. The numerator will represent the total number of minutes containing documented discussion of the Peer Review data presented. The denominator will represent all minutes containing peer review data. Compliance of this action will be reported to the Quality Patient Safety Committee (QPS) until compliance of 90 percent or higher is achieved and sustained for two consecutive quarters.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[41] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[42]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[43] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[44]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[45]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[46] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

[41] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded this handbook and replaced it with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[42] VHA Handbook 1100.19.

[43] VHA Handbook 1100.19.

[44] VHA Handbook 1100.19.

[45] VHA Handbook 1100.19.

[46] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[47]

The OIG interviewed key managers and reviewed the privileging folders of 29 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires Focused Professional Practice Evaluation processes "to be defined in advance, using objective criteria accepted by the LIP."[48] The OIG found that service chiefs did not document that LIPs had accepted the criteria in advance. When LIPs are not aware of the criteria used to evaluate their performance, they may not understand expectations. The Chief of Staff described a verbal process to review Focused Professional Practice Evaluation criteria with LIPs. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

VHA also requires facility leaders to monitor the LIPs' performance by regularly completing an Ongoing Professional Practice Evaluation.[49] Additionally, in carrying out its responsibilities under the Inspector General Act, the OIG is authorized to "have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material" related to the agency's programs and operations.[50] The OIG requested specific documentation on November 14, 2022, to determine whether facility staff complied with selected privileging requirements for LIPs. This was due to the OIG no later than November 29, 2022.

Facility staff did not provide complete documentation at the time of the OIG's initial request or during the on-site review. Therefore, the OIG could not determine whether staff completed Ongoing Professional Practice Evaluations for some of the LIPs who were reprivileged. The Credentialing and Privileging Manager stated service chiefs did not provide requested documentation supporting completed Ongoing Professional Practice Evaluations, and the Chief of Staff reported being unaware the Credentialing and Privileging Manager did not receive the requested documents.

[47] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts – Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[48] VHA Handbook 1100.19; VHA Directive 1100.21(1).

[49] VHA Handbook 1100.19; VHA Directive 1100.21(1).

[50] IG Act § 406(a)(1)(A).

Recommendation 3

3. The Chief of Staff ensures service chiefs complete Ongoing Professional Practice Evaluations prior to reprivileging to ensure continuous delivery of quality care.

Medical center concurred.

Target date for completion: June 30, 2024

Medical center response: Prior to reprivileging, the Chief of Staff ensures that Service Chiefs are completing Ongoing Professional Practice Evaluations (OPPE) to ensure continuous delivery of care. In November 2023, the Chief of Staff updated the reporting format for Service Chiefs in the MSEC Credentials Committee to include OPPE data and that it has been completed prior to reprivileging providers. Ongoing Professional Practice Evaluations/Focused Professional Practice Evaluations forms will be submitted to the Chief of Staff and the Credentialing and Privileging Program Manager for review prior to reprivileging. The Credentialing and Privileging Program Manager will track and monitor OPPE every month. The numerator equals the number of providers undergoing reprivileging with a completed OPPE summary on file. The OPPE summary contains documentation review that is part of the provider profile. The documentation review is from the service chief as part of a provider's OPPE. The denominator equals the total number of providers undergoing reprivileging. The Credentialing and Privileging Program Manager will report the monthly compliance to the Quality Patient Safety Committee (QPS) until 90 percent compliance is achieved and sustained for six consecutive months.

VHA requires service chiefs to consider and maintain relevant specialty-specific data during the ongoing monitoring of LIPs' performance.[51] The OIG found service chiefs did not consistently evaluate LIPs using specialty-specific criteria, which may result in overlooking practice deficiencies that could pose patient safety risks. The Chief of Staff reported service chiefs did not always use a standardized Ongoing Professional Practice Evaluation template with specialty-specific criteria.

Recommendation 4

4. The Chief of Staff ensures service chiefs use specialty-specific criteria in the professional practice evaluations of licensed independent practitioners.

[51] VHA Handbook 1100.19; VHA Directive 1100.21(1). For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

Medical center concurred.

Target date for completion: December 31, 2024

Medical center response: The Chief of Staff, in collaboration with the Credentialing and Privileging Program Manager, will ensure that all Service Chiefs use service-specific criteria in the Professional Practice Evaluations of Licensed Independent Practitioners. The Credentialing and Privileging Program Manager has provided Clinical Chart Review Form templates to each Service Chief for their specialty. Service Chiefs will then ensure these forms contain service-specific criteria that aligns with the National Credentialing and Privileging Office recommendations. These forms are awaiting approval from the MSEC Credentials Committee. The Credentialing & Privileging Program Manager is developing an audit tool and will conduct an audit review of five (5) Ongoing Professional Practice Evaluations (OPPE) and two (2) Focused Professional Practice Evaluations (FPPE) of Licensed Independent Practitioners (LIPs) per month to ensure compliance with use of the approved form. A report will be submitted to the Quality, Patient, Safety, and Value Committee starting March 2024 until 90 percent compliance has been achieved for six consecutive months.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care (EOC) inspections and track issues until they are resolved. The goal of VHA's EOC program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[52] The EOC program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[53]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[54]

During the OIG's review of the EOC, the inspection team examined relevant documents, interviewed managers and staff, and inspected six patient care areas:

- Community living center (eighth floor)
- Emergency Department
- Intensive care unit (6A)
- Medical/surgical inpatient unit (7B)
- Mental health inpatient unit (7S)
- Primary care clinic (Red Team)

Environment of Care Findings and Recommendations

VHA requires facility leaders to have a comprehensive EOC program, which includes staff conducting environmental inspections at "a minimum of once per fiscal year in non-patient care

[52] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[53] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[54] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.)
VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

areas, and twice per fiscal year in all areas where patient care is delivered" and documenting completion of each inspection.[55] Additionally, VHA requires the comprehensive EOC rounds coordinator to organize and schedule physical rounds and maintain inspection records.[56] The OIG reviewed the medical center's FY 2022 environmental inspection reports and found that staff did not inspect some clinical areas at least twice, which could have prevented them from proactively identifying unsafe conditions. The Chief of Facility Management explained that all three positions in the safety department (EOC coordinator and two safety specialists) had been vacant during some of FY 2022, which resulted in a lack of oversight of the EOC program. The Chief of Facility Management further reported assigning one individual to the safety department, but that employee was unable to cover all responsibilities.

Recommendation 5

5. The Associate Director ensures the Comprehensive Environment of Care Rounds Coordinator or designee schedules environment of care inspections and staff complete and document them at the required frequency.

[55] VHA Directive 1608.

[56] VHA Directive 1608.

Medical center concurred.

Target date for completion: June 30, 2024

Medical center response: The Assistant Medical Center Director began overseeing Environment of Care Rounds in FY24. The Assistant Medical Center Director will ensure the Comprehensive Environment of Care Coordinator schedules environment of care inspections at the required frequency and ensures appropriate documentation of inspections. An Environment of Care Coordinator (EOCC) was identified hired at the facility level to schedule and coordinate all Environment of Care rounds. Previously this was unoccupied and had been assigned as a collateral duty. Health occupancy spaces will have the minimum two required inspections each fiscal year. Administrative occupancy spaces are only required to be inspected once per fiscal year. The EOCC is responsible for tracking and monitoring the number of environmental care rounds completed each month using an electronic database. The FY24 Environment of Care rounding schedule was presented to the Environment of Care Committee (EOC), which is chaired by the Assistant Medical Center Director, on September 26, 2023, to ensure the frequency of scheduled environment of care rounds is in line with directive requirements. Compliance of this action will be reported to the Quality Patient Safety Committee (QPS) until compliance of 100 percent is achieved and sustained for six consecutive months. The numerator will be represented by the number of completed Environment of Care rounds per month in health occupancy spaces. The denominator will be represented by the total number of scheduled rounds per month in health occupancy spaces.

VHA requires all medical facilities to "provide a safe, clean, and high quality environment of care for Veterans, their families, visitors, and employees."[57] In the six patient care areas inspected, the OIG found one or more of the following: dusty patient care areas, dirty ventilation grills, and dirty refrigerators containing expired food.[58] Dirty patient care and food storage areas increase the risk of contamination and pathogen exposure. The Interim Director stated these deficiencies resulted from critical staff vacancies in Environmental Management Services. The Chief of Nutrition and Food Services attributed expired food and dirty refrigerators to a lack of oversight.

Recommendation 6

6. The Associate Director ensures staff keep patient care areas safe and clean.

[57] VHA Directive 1608.

[58] The OIG noted dusty patient care areas in the primary care clinic and community living center, dirty ventilation grills in the primary care clinic and Emergency Department, and dirty refrigerators containing expired food in the intensive care unit and medical/surgical inpatient unit.

Medical center concurred.

Target date for completion: October 31, 2024

Medical center response: The Associate Director in combination with the Environmental Service Chief were able to fill previous critical vacancies. In November 2023, a task checklist was developed and implemented for EMS staff that outlines daily and weekly responsibilities, based on the Veterans Health Administration standards of cleanliness. Within the daily and weekly responsibilities are tasks that include dusting and cleaning of dirty ventilation grills. Nutrition and Food Services developed a checklist for staff to review during weekly refrigerator checks that includes inspecting refrigerators for cleanliness and the removal of expired food. During weekly environment of care rounds, team members will review assigned areas for evidence of dust contamination, dirt, and expired food. The Environment of Care Coordinator (EOCC) will report the deficiencies found to the Quality Patient Safety Committee monthly until six consecutive months with less than or equal to 10% of the deficiencies relate to cleanliness. The number of findings related to cleanliness and food expiration will represent the numerator, and total Environment of Care deficiencies identified will represent the denominator.

VHA requires staff to periodically test panic alarms in inpatient mental health units and document VA police response times.[59] The OIG found no evidence that staff documented police response times during monthly panic alarm testing. Failure to monitor police response times for panic alarm testing reduces awareness of opportunities for improvement, which may place patients, visitors, and staff at risk in emergency situations. The Deputy Chief of Police reported being unaware of the requirement to record police response times to panic alarm testing.

Recommendation 7

7. The Medical Center Director ensures staff document police response times to panic alarm testing in the mental health inpatient unit.

[59] VHA Directive 5019.02(1), *Harassment, Sexual Assaults and Other Defined Public Safety Incidents in VHA,* September 12, 2022, amended October 13, 2022; VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients,* May 12, 2017; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," October 18, 2022; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," April 10, 2023.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Medical Center Director will ensure that police response times to panic alarm testing in the inpatient mental health unit is tested and documented monthly. Panic alarm testing was conducted monthly but did not include response times. The Physical Security Specialist created a document to track police response time to panic alarm testing in the inpatient mental health unit which went into effect in February 2024. The Physical Security Specialist will monitor compliance with the denominator represented by monthly panic alarms tested in the inpatient mental health unit. The numerator will be represented by panic alarms tested in the inpatient mental health unit with documented police response times each month. Compliance and response times will be reported to Quality Patient Safety Committee monthly until 90 percent compliance is sustained for six months.

VHA requires staff to test over-the-door alarms per the manufacturer's recommendations for all doors to sleeping rooms on inpatient mental health units.[60] The manufacturer's recommendations are that staff test the alarms weekly and an outside maintenance provider tests them annually. The OIG found that staff only tested over-the-door alarms monthly in FY 2023. If staff do not test door alarms per the manufacturer's recommendations, the alarms may fail to alert them when patients are in immediate danger. The Associate Chief of Staff for Mental Health reported being unaware of the requirement to follow the manufacturer's recommendations for weekly testing.

Recommendation 8

8. The Medical Center Director ensures staff test over-the-door alarms based on the manufacturer's recommendations for mental health inpatient unit sleeping rooms.

[60] VHA Directive 1167; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," October 18, 2022; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," April 10, 2023.

Medical center concurred.

Target date for completion: June 30, 2024

Medical center response: The inpatient behavioral health Nurse Manager created a log for over-the-door alarm weekly testing per the manufacturer's recommendations. Inpatient behavioral health nursing staff began weekly testing of over-door alarms in April 2023 and documented that testing on the testing log. This log is reviewed by the Nurse Manager. Compliance with over-the-door alarm testing reached 100 percent and was sustained for six consecutive months as of September 2023. The Syracuse VA has continued to maintain 100 percent compliance with weekly over-the-door alarm testing through February 2024. Annual testing was completed in October of 2023 by facility engineering staff as the installers of the system and added to the annual preventative maintenance grid for engineering. Compliance of this action will be reported to the Quality Patient Safety Committee (QPS) until compliance of 100 percent or higher is achieved and sustained for six months.

VHA requires staff to check all ceiling tiles semiannually to make sure they are secure.[61] Throughout the mental health inpatient unit, including patient sleeping rooms, the OIG observed ceilings were non-solid and determined staff did not check that ceiling tiles were secure, despite marking the requirement as *met* on the mental health EOC checklist. Failure to check the security of the ceiling tiles may allow patients access to unsafe spaces. The Chief of Facility Management reported being unaware of the requirement for staff to check the tiles semiannually.

Recommendation 9

9. The Medical Center Director ensures staff check all mental health inpatient unit ceiling tiles semiannually.

[61] VHA Directive 1167; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," October 18, 2022; National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," April 10, 2023.

Medical center concurred.

Target date for completion: January 1, 2025

Medical center response: The Chief of Facility Management Service in collaboration with the inpatient mental health unit Nurse Manager will ensure all ceiling tiles are checked throughout the inpatient mental health unit including sleeping rooms to make sure they are secure semiannually. A check list will be developed listing all the locations on the inpatient mental health unit with non-solid ceilings that will need to be reviewed, along with a schedule for completing the ceiling checks in each location. The Chief of Facility Management Service will report compliance with ceiling tile inspections and ensuring they are secured on all the locations on the inpatient mental health unit. The goal will be to achieve 100 percent of tiles remaining secure and will be monitored until six months of consecutive compliance has been achieved. Compliance will be reported to the Quality Patient Safety Committee quarterly for four quarters. The denominator will be the number of locations in the inpatient mental health unit with non-solid ceiling tiles requiring semiannual inspection and the numerator will be the locations with non-solid ceiling tiles that have been inspected and remained secured.

The Joint Commission requires staff to inspect, test, and maintain all medical equipment for scheduled maintenance activity.[62] The OIG observed staff used stickers affixed to the medical equipment to show when scheduled maintenance was last completed and due again; however, the OIG found 21 pieces of medical equipment overdue for scheduled maintenance.[63] If staff do not regularly inspect and service medical equipment, it may malfunction during use.

The VISN 2 Healthcare Technology Manager explained the biomedical positions at this medical center were staffed with employees who were assigned to the VISN and reported providing oversight and supervision. The OIG determined the VISN 2 Healthcare Technology Manager became aware that some equipment, identified during the VISN's September 2022 annual workplace evaluation, was overdue for scheduled maintenance. The VISN 2 Healthcare Technology Manager reported being unaware of the prior report showing deficiencies with scheduled maintenance, or that, following the annual workplace evaluation, VISN biomedical staff found over 1,400 pieces of patient care equipment with overdue scheduled maintenance.[64] The VISN 2 Healthcare Technology Manager detailed taking actions after identifying these deficiencies, including determining how many items were high-risk equipment and prioritizing their maintenance, seeking staff from other VHA facilities to volunteer to perform the needed

[62] The Joint Commission, *Standards Manual*, E-dition, EC.02.04.03, January 1, 2020.

[63] The overdue medical equipment included but was not limited to cardiac defibrillators, battery chargers, and portable suction equipment.

[64] The Joint Commission, *Final Accreditation Report VA Healthcare Network Upstate New York at Syracuse,* October 2021. The facility's EOC inspection deficiencies list from February 5, 2020, to August 31, 2022, included 23 pieces of medical care equipment that were overdue for scheduled maintenance.

maintenance, and establishing contracts with outside vendors (biomedical staff) to perform overdue scheduled maintenance.[65]

The OIG determined that VISN leaders did not bring in additional staff to help complete the overdue maintenance. The VISN 2 Healthcare Technology Manager described sending a request for volunteers across VHA and selecting two biomedical staff members who backed out prior to coming on-site to assist with maintenance. Additionally, the VISN 2 Healthcare Technology Manager reported directing the VISN biomedical staff to ask for volunteer support across VISN 2, but no one volunteered. The VISN 2 Healthcare Technology Manager further discussed the history of the chief of biomedical position, which was vacant starting March 2022 and then filled with three staff members from other VISN 2 locations, none of whom were in chief or assistant chief roles at their facilities. The chief of biomedical position was permanently filled in December 2022. The VISN 2 Healthcare Technology Manager also reported converting the biomedical administrative assistant position from part-time to full-time and recruiting for two additional biomedical staff.

The VISN 2 Healthcare Technology Manager reported initiating contracts with outside vendors to perform the overdue maintenance in early November 2022; the first vendor started at the medical center the week of OIG's site visit in March 2023. The second contract had not yet started, and the VISN 2 Healthcare Technology Manager was unable to provide the start date, but stated the goal for completing the overdue scheduled maintenance was the end of December 2023. The OIG remains concerned about the VISN 2 Healthcare Technology Manager's lack of awareness, oversight, and timely actions to support the facility needs.

Recommendation 10

10. The Veterans Integrated Service Network Director ensures the Medical Center Director has sufficient biomedical staff and confirms they inspect and test all medical equipment for scheduled maintenance.

[65] "High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment." The Joint Commission, *Standards Manual*, E-dition, EC.02.04.03, August 27, 2023.

Veterans Integrated Service Network concurred.

Target date for completion: July 31, 2024

Veterans Integrated Service Network: The Syracuse Healthcare Technology Management (HTM) Staffing levels in Q2, Q3, and Q4 of fiscal year 2023 were 72%, 88% and 83% respectively. In fiscal year 2024, year to date staffing has increased to 88%. The position is actively being recruited. The Supervisory Biomedical Engineer position became vacant on 10/18/2023, it was posted on 10/31/23 and remains in active recruitment. The Supervisory Biomedical Equipment Support Specialist (Supervisory BESS) is providing coverage. The BESS position was posted on USA Jobs on 6/14/2023 and a selection was made. The employee is expected to start in April 2024. A supplementary staffing contract was acquired in October 2023 to provide dedicated staff to address the overdue backlog of 1400 preventative maintenance inspections.

Syracuse Preventive Maintenance (PM) compliance has been at 100% for High- Risk (HR) equipment since May 2023 (Compliance requirement is 100% for HR). The Non-High Risk (NHR) equipment has been at 100% except for 2 months in which compliance were at 96.8% (November) and 97.9% (January) (Compliance goal is 100% for NHR). There were no overdue High-Risk PMs among the 1400 overdue PMs. Syracuse has 12 Overdue NHR PMs remaining that will be completed by end of March 2024.

VHA requires the VISN director to ensure each medical facility within their VISN has sufficient resources for biomedical engineering functions.[66] VHA has also assigned responsibilities for the biomedical program to the medical center director, which include ensuring sufficient resources and support to improve operations and effectiveness and assigning responsibility for adherence to processes to the chief biomedical engineer; however, the VISN 2 Healthcare Technology Manager reported directly supervising the medical center's chief biomedical engineer position.[67] The OIG determined that the Medical Center Director did not have oversight of the biomedical program for the last three and a half years; instead, the VISN had supervisory responsibility.

Recommendation 11

11. The Veterans Integrated Service Network Director ensures compliance with VHA Directive 1860, *Biomedical Engineering Performance Monitoring and Improvement*, for oversight structure of the medical center's biomedical program.

[66] VHA Directive 1860, *Biomedical Engineering Performance Monitoring and Improvement*, March 22, 2019.

[67] VHA Directive 1860.

Veterans Integrated Service Network concurred.

Target date for completion: March 31, 2024

Veterans Integrated Service Network: The proposal to create a sustainable Environment of Care Service Line in VISN 2 was presented to Executive Leadership Council (ELC) and approved on February 26, 2019. The goals of this realignment were to:

- Significantly reduce risk to Veterans, employees, and visitors. We will achieve this through redesign and use of proven methodologies and processes to evolve from its current state of facilities and equipment management to a best practice model for both VA and private sector.
- Standardize policies and SOPs across the VISN.
- Create a deep cadre of professional Biomedical and General (Healthcare) Engineers to meet current staffing needs and better manage the risks and modern technologies needed to support an older and complex infrastructure.
- Provide for better compliance with the numerous internal and external regulations and standards.
- Improve the effectiveness of the VISN and VAMC EOC Committees' ability to manage and reduce risk.
- Involve multiple internal stakeholders to recognize, report, and follow up on potential safety, medical equipment, and critical utility potential hazards prevalent in older facilities.
- Reduce the possibilities of untoward events and adverse media attention from failed facilities, utilities, and medical equipment.

As a result of this restructuring, the VISN HTM has developed Standard Operating Procedures (SOPs) and competencies across the VISN. The VISN has made significant strides in documentation of PMs and unscheduled repairs; has added professional biomedical engineers at smaller facilities; improved timely notification of medical device incidents; implemented an incoming inspection program of medical equipment before use in clinical setting, and increased input in medical equipment planning and installation.

Under the VISN HTM leadership, a training budget was created to offer HTM service line staff the opportunity to bridge gaps in knowledge. Syracuse has benefited from VISN HTM staff oversight in that, the Albany Biomedical Equipment Support Specialist (BESSs) traveled to Syracuse in June 2023 and December 2023 to assist with High-risk Preventative Maintenance completion.

The VISN has responsibility for HTM in partnership with the Medical Center. We work collaboratively to ensure oversight of the program. The VISN HTM Chief meets monthly with the Syracuse Assistant Director and Syracuse Supervisory BESS to discuss the following topics including but not limited to staffing, Preventative Maintenance, HTM projects, medical

equipment procurements and employee recognition. During these meetings, the VISN HTM Chief and the Syracuse Supervisory BESS share if additional support is required from facility leadership regarding space, medical equipment installation, medical equipment inventory and medical equipment report of surveys or other HTM intersections with other service lines. The HTM information shared with the Assistant Director, is communicated during morning huddles with facility medical center director.

After the Syracuse OIG finding, the VISN HTM Deputy Chief position came into effect June 2023. The VISN HTM Deputy Chief has supervisory responsibility to focus on operations oversight and meets weekly with the Syracuse Supervisory BESS. During these touchpoints, topics include but are not limited to preventative maintenance, corrective maintenance, contracts, patient safety items and upcoming or overdue VISN action items.

The VISN HTM Chief conducts a biweekly Supervisory Huddle, and a monthly HTM Workgroup huddle is led by the VISN HTM Deputy Chief. In that huddle, they cover National Key Performance Indicators (KPIs) and Medical Equipment Management Plan (MEMP) efficiency metrics, fiscal and other information. Additional topics may include High Reliability Organization presentations, all employee survey action plans, maintenance definition remediation dashboards, scope of service updates, medical imaging equipment deployments, contract reductions from technical trainings and annual program assessment progress updates. The VISN HTM Chief reports quarterly to the VISN Healthcare Operations Council which report to the VISN ELC, chaired by the Network Director.

The facility HTM staff serve as a member of the facility Equipment Committee as the subject matter expert to ensure compatibility of medical equipment and consult on medical equipment replacement planning. The Equipment Committee reports monthly to the Facility Environment of Care Committee, which reports monthly to the Local Leadership Committee, chaired by the Medical Center Director. The facility leadership is involved in the recruitment of the Syracuse Supervisory Biomedical Engineer position. The Medical Center Director funds the HTM department Fund Control Points for repairs and contracts. The Medical Center reviews the budget proposal for this and grants additional funding as needed.

The OIG acknowledged the creation (as a result of the findings during this inspection) of a new position in June 2023, the VISN Healthcare Technology Management Deputy Chief, to further support oversight of these critical functions.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[68] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[69] The suicide rate for veterans was higher than for nonveteran adults during 2020.[70] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[71]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[72] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[73]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[74]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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[68] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[69] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

[70] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[71] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[72] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[73] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[74] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

In ambulatory care settings, VHA requires designated staff to complete the Comprehensive Suicide Risk Evaluation following a positive suicide screen. Providers should complete the evaluation on the same calendar day unless the patient needs urgent or emergent care; then it is acceptable to complete it within 24 hours.[75] The OIG estimated that staff did not complete the Comprehensive Suicide Risk Evaluation for 52 (95% CI: 38 to 66) percent of patients with positive screens, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[76] For completed evaluations, the OIG estimated that staff did not perform 33 (95% CI: 15 to 53) percent on the same calendar day as the positive screen. Failure to complete the evaluation, or to complete it on the same day, poses a patient safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The Chief of Ambulatory Care reported that despite receiving education, staff were unaware of the requirement to complete the evaluation in addition to the routine patient documentation. The Suicide Prevention Coordinator identified a lack of real-time monitoring tools and the need for ongoing education as barriers to staff completing evaluations. The Associate Chief of Staff for Mental Health also explained that staff may not fully understand the medical center's standard operating procedure.[77]

Recommendation 12

12. The Medical Center Director ensures designated staff complete the Comprehensive Suicide Risk Evaluation on the same calendar day as a positive suicide risk screen, when clinically appropriate, for all ambulatory care patients.

[75] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

[76] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

[77] Syracuse VA Medical Center, "Provision of Suicide Prevention Screenings & Safety Plans in Ambulatory Care Settings" (standard operating procedure), March 2023.

Medical center concurred.

Target date for completion: October 1, 2024

Medical center response: Education was provided to primary care providers and nurse case managers, as well as specialty clinic providers related to the Comprehensive Suicide Risk Evaluation (CSRE) completion in April of 2023. Communication pathways have been developed for providers whose patients have a positive screen to allow transition to a mental health worker for assistance with completing the Comprehensive Suicide Risk Evaluation. The Suicide Prevention Coordinator currently tracks facility compliance with CSRE and will audit all electronic health records of patients with a positive suicide risk screen for a completed Comprehensive Suicide Risk Evaluation within the same calendar day. The Suicide Prevention Coordinator or designee will report compliance monthly to the Quality Patient Safety Committee until 90% compliance has been achieved and maintained for six consecutive months. The denominator will be all positive Columbia-Suicide Severity Risk Screens and patients who have a completed Comprehensive Suicide Risk Evaluation within the same calendar day will be the numerator.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided 12 recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines 12 OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the VISN Director, Medical Center Director, Chief of Staff, and Associate Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• Staff record the Peer Review Committee's formal discussions related to changes in peer review level assignments in the meeting minutes. • The Medical Staff Executive Committee reviews data provided by the Peer Review Committee to determine the need for further action.
Medical Staff Privileging	• Service chiefs complete Ongoing Professional Practice Evaluations prior to reprivileging to ensure continuous delivery of quality care. • Service chiefs use specialty-specific criteria in the professional practice evaluations of licensed independent practitioners.
Environment of Care	• The Comprehensive Environment of Care Rounds Coordinator or designee schedules environment of care inspections and staff complete and document them at the required frequency. • Staff keep patient care areas safe and clean. • Staff document police response times to panic alarm testing in the mental health inpatient unit. • Staff test over-the-door alarms based on the manufacturer's recommendations for mental health inpatient unit sleeping rooms. • Staff check all mental health inpatient unit ceiling tiles semiannually. • The Veterans Integrated Service Network Director ensures the Medical Center Director has sufficient biomedical staff and confirms they inspect and test all medical equipment for scheduled maintenance.

Review Areas	Recommendations for Improvement
Environment of Care, cont.:	• The Veterans Integrated Service Network Director ensures compliance with VHA Directive 1860, *Biomedical Engineering Performance Monitoring and Improvement*, for oversight structure of the medical center's biomedical program.
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the Comprehensive Suicide Risk Evaluation on the same calendar day as a positive suicide risk screen, when clinically appropriate, for all ambulatory care patients.

Appendix B: Medical Center Profile

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

Table B.1. Profile for Syracuse VA Medical Center (528)
(October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$420,806,190	$473,121,021	$505,129,159
Number of: • Unique patients	50,987	50,195	44,684
• Outpatient visits	532,152	602,872	519,464
• Unique employees§	1,749	1,650	1,505
Type and number of operating beds: • Community living center	48	48	48
• Medicine	60	60	60
• Mental health	16	16	16
• Rehabilitation medicine	5	5	5
• Spinal cord	15	26	26
• Surgery	13	13	13
Average daily census: • Community living center	32	20	22
• Medicine	43	52	55
• Mental health	10	10	8
• Rehabilitation medicine	2	2	2
• Spinal cord	13	11	13

[1] VHA medical facilities are classified according to a 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." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census, cont.:			
• Surgery	6	6	5

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

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

**October 1, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 4, 2024

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

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

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

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

Thank you for the OIG's Comprehensive Healthcare Inspection at the Syracuse VA Medical Center in New York in March 2023.

I concur with the OIG's findings and recommendations, and the facility's submitted action plans.

(Original signed by:)

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

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: March 1, 2024

From: Director, Syracuse VA Medical Center (528)

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

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

I have reviewed the draft report for the Comprehensive Healthcare Inspection of the Syracuse VA Medical Center in New York. I concur with the findings and recommendations from the OIG.

(Original signed by:)

Mark Murdock
Medical Center Director

OIG Contact and Staff Acknowledgments

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