



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

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

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Figure 1. Bath VA Medical Center of the VA Finger Lakes Healthcare System in New York.

Source: <https://www.va.gov/finger-lakes-health-care/> (accessed August 11, 2023).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
HR	human resources
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 VA Finger Lakes Healthcare System, which includes the Bath and Canandaigua VA Medical Centers and multiple outpatient clinics in New York and Pennsylvania. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure 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 VA Finger Lakes Healthcare System during the week of July 24, 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 healthcare system'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 three recommendations to the Medical Center Director and Chief of Staff in the following areas of review: 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 system. 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. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 19.

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 21–22, and the responses within the body of the report for the full text of the directors’ comments). The OIG considers recommendation 1 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

A handwritten signature in black ink, reading "John D. Daigh Jr. M.D." in a cursive script.

JOHN D. DAIGH JR., M.D.
Assistant Inspector General
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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Finger Lakes Healthcare System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so 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 VA Finger Lakes Healthcare System includes the Bath and Canandaigua VA Medical Centers and multiple outpatient clinics in New York and Pennsylvania. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review during the week of July 24, 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 healthcare system leaders complete corrective actions. The Director's 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 VA Finger Lakes Healthcare System occurred in June 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in April 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 healthcare system’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 healthcare system 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 healthcare system had a leadership team consisting of the Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the ADPCS was the most tenured leader, having started in November 2014. The Director and Associate Director had been in their positions since May 2019 and March 2021, respectively, and the Assistant Director joined the team in June 2023. The Chief of Staff acted in the position from December 31, 2022, until being permanently assigned on July 17, 2023.

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.

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

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of \$355,126,755 had decreased less than 1 percent compared to the previous year's budget of \$356,159,095.¹⁰ System leaders stated the budget was sufficient and they used funds to purchase equipment and supplies. The Associate Director reported a medical services budget surplus of about \$28 million for FY 2022, attributing it mostly to salary dollars not used due to hiring delays. The Associate Director also said the current FY's \$10 million surplus could change if leaders hired additional employees, but they would return any remaining money to the VISN. Regarding funding for equipment, the Associate Director stated leaders spent the \$3.8 million allocated and used additional funding of about \$85,000 to support facility operations.

The Director stated leaders would close the Coudersport VA Clinic in Pennsylvania at the end of FY 2023 due to low patient volume and inability to recruit employees to work in the rural area.¹¹ In addition, leaders reported closing Community Living Center-1 in Bath three years previously for construction, and it remained closed because of difficulty hiring nurses. The ADPCS stated hiring nursing staff to work in community living centers continued to be the biggest challenge despite using recruitment strategies such as hiring a nurse recruiter, offering incentives and bonuses, and implementing special salary rates. The Senior Strategic Business Partner reported the top three hardest-to-fill occupations were licensed practical nurses, nursing assistants, and custodial workers. The Associate Director added that leaders filled critical positions, such as for nursing and mental health professionals, as quickly as possible.

In addition, the Associate Director reported concerns related to timely recruiting and hiring of potential staff, as well as a lack of on-site human resources (HR) and labor relations employees because VA had centralized them. The ADPCS said the new HR processes had put a strain on managers, adding that managers believed they were completing HR tasks, and centralized HR staff lacked knowledge specific to the facility. To address these challenges, the Senior Strategic Business Partner discussed hosting a monthly HR Power Hour that provided facility managers training on various HR-related topics; the sessions were recorded, and presenters solicited feedback for future topics.

¹⁰ Veterans Health Administration (VHA) Support Service Center.

¹¹ The Coudersport VA Clinic in Pennsylvania, part of the VA Finger Lakes Healthcare System, is closed according to its published operating status. "Operating Status," Department of Veterans Affairs, accessed January 16, 2023, <https://www.va.gov/finger-lakes-health-care/status/>.

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 healthcare system over time.¹⁴

The system’s scores for all three years were comparable to VHA averages. System leaders stated they encourage employees to use any available methods to report concerns, stressing that reporting through the chain of command is not necessary. The Director expressed that one of the best things about VA’s culture is leaders who support staff in disclosing violations, adding that staff can share lessons learned with other VA facilities.

**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
Bath VA Medical Center	3.8	–	–
Canandaigua VA Medical Center	3.7	–	–
VA Finger Lakes Healthcare System	–	3.9	3.9

Source: VA All Employee Survey (accessed December 27, 2022).

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

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

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.

¹⁴ Effective October 1, 2018, the Bath VA Medical Center and Canandaigua VA Medical Center merged to form the VA Finger Lakes Healthcare System. The All Employee Survey scores were combined in FY 2021 to represent the healthcare system.

Medical Home (primary care), and Specialty Care surveys.¹⁵ The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

Inpatient results indicate patient satisfaction improved over all three years. The Associate Director stated opportunities remained for staff to improve the patient experience; however, patients were very happy with their care overall. System leaders described activities to improve inpatient experiences that included facility walk-arounds by leaders and the Patient Experience Officer, allowing leaders to address patient concerns in real-time; use of communication boards in patient rooms; and decreased environmental noise during the night to support better sleep.

Primary and specialty care survey results imply that patients were satisfied with their outpatient experiences. To improve the outpatient experience, the Chief of Staff reported implementing a new electronic process for managing clinic cancellation requests to ensure continuity and access to care when cancellations occur.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: <i>Would you recommend this hospital to your friends and family?*</i>	69.5	64.3	69.7	69.2	68.9	81.6
Patient-Centered Medical Home: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	82.5	86.2	81.9	86.2	81.7	86.3
Specialty Care: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	84.8	88.4	83.3	87.3	83.1	87.0

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

*The response average is the percent of “Definitely yes” responses.

†The response average is the percent of “Very satisfied” and “Satisfied” responses.

¹⁵ “Patient Experiences Survey Results,” VHA Support Service Center.

Identified Factors Related to Possible Lapses in Care and Healthcare System 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.¹⁶ According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.¹⁷ A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.¹⁸

"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)."¹⁹ 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."²⁰ 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."²¹ To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.²²

¹⁶ Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

¹⁷ The Joint Commission, *Standards Manual*, E-edition, July 1, 2022. 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>.

¹⁸ Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

¹⁹ 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.

²⁰ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

²¹ VHA Directive 1004.08.

²² 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.)

The OIG requested a list of sentinel events, institutional disclosures, and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. System leaders explained that quality management staff inform leaders of adverse events when they occur, track sentinel events, and educate staff through safety forums. In addition, the leaders said that after discussing the event with quality management staff, they decide whether the incident meets sentinel event criteria or warrants a root cause analysis.²³

For institutional disclosures, the Risk Manager assigned to the Bath facility said patient safety managers, risk managers, and the Chief of Quality Management discuss serious events that occur at the healthcare system, and the Chief of Staff decides whether to conduct an institutional disclosure.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

²³ A root cause analysis “is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls.” VHA Directive 1050.01(1).

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.²⁴ 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.²⁵ Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.²⁶

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.²⁷ 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.²⁸

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.²⁹ 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."³⁰ 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.³¹

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed deaths that occurred within 24 hours of inpatient admission during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

²⁴ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

²⁵ VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

²⁶ VHA Directive 1100.16.

²⁷ VHA Handbook 1050.01; VHA Directive 1050.01(1).

²⁸ The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

²⁹ 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.

³⁰ VHA Directive 1190.

³¹ VHA Directive 1190.

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.”³² 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.”³³

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.³⁴ LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.³⁵

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.³⁶

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.³⁷ 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

³² VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook 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.)

³³ VHA Handbook 1100.19.

³⁴ VHA Handbook 1100.19.

³⁵ VHA Handbook 1100.19.

³⁶ VHA Handbook 1100.19.

³⁷ VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.³⁸

The OIG interviewed key managers and selected 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 practitioners from other facilities with equivalent specialized training and similar privileges to complete Ongoing Professional Practice Evaluations for LIPs who are part of a solo service or specialty.³⁹ The OIG found that a primary care provider evaluated a solo pathology LIP. This resulted in the LIP providing care without a thorough practice evaluation, which could negatively affect patient safety. The Chief of Staff acknowledged the deficiency but was not in the position during the review period and was unable to provide a reason the evaluation was not sent out for external review.

Recommendation 1

1. The Chief of Staff ensures practitioners from other facilities with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations for solo licensed independent practitioners.⁴⁰

³⁸ 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.

³⁹ A solo LIP is “the only individual at the VHA medical facility who performs the privileges that have been granted.” Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer revision memo, “Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators,” May 18, 2021; VHA Directive 1100.21(1).

⁴⁰ The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Healthcare System has one solo licensed independent practitioner and had corrected the identified oversight at the time of the Comprehensive Healthcare Inspection Program survey. The Chief of Staff had implemented a corrected process wherein a provider at a different VA facility, who serves in a peer role and has equivalent specialized training and similar privileges, completes the Ongoing Professional Practice Evaluations for solo licensed independent practitioners. The Chief of Staff reviews and additionally signs off on the Ongoing Professional Practice Evaluations and presents the Ongoing Professional Practice Evaluations to the Executive Committee of the Medical Staff. Compliance is monitored in the Executive Committee of the Medical Staff and 100 percent compliance was achieved on August 9, 2023, when the solo licensed independent practitioner was reappointed by the Executive Committee of the Medical Staff. Ongoing 100 percent compliance was reported in the Annual Facility Credentialing and Privileging Program Assessment as attested to by the Associate Director for Patient Care Services, Chief of Staff, and Medical Center Director to the VHA Credentialing and Privileging Office on January 19, 2024.

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 inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."⁴¹ The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.⁴²

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 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.⁴³

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

- Bath VA Medical Center
 - Community living center (Warrior's Way)
 - Inpatient medical/surgical unit (Acute Care 3B)
 - Primary care clinic
 - Urgent Care Center
- Canandaigua VA Medical Center
 - Community living center (Garden View)
 - Primary care clinic

Environment of Care Findings and Recommendations

VHA requires staff to conduct environment of care inspections "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is

⁴¹ 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.)

⁴² 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.

⁴³ 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.)

delivered.”⁴⁴ The OIG reviewed FY 2022 environment of care inspection reports and found staff did not inspect all non-patient care areas as required. Failure to inspect non-patient care areas could hinder staff’s proactive identification of unsafe conditions. The Safety Manager reported inadvertently neglecting to add some areas to the FY 2022 environment of care inspection schedule due to competing priorities during the COVID-19 pandemic.

Recommendation 2

2. The Medical Center Director ensures staff conduct environment of care inspections in non-patient care areas at least once per fiscal year.

Healthcare system concurred.

Target date for completion: August 31, 2024

Healthcare system response: The Medical Center Director reviewed the recommendation and did not identify additional reasons for noncompliance. In March 2023, the Medical Center Director realigned the Comprehensive Environment of Care Program for all VA Finger Lakes campuses under Environmental Services and appointed an Environment of Care Coordinator to ensure all required inspections are completed each fiscal year. One hundred percent of non-patient care areas were inspected at least once in fiscal year 2023. The Environment of Care Coordinator will track, monitor, and report compliance to the Environment of Care Committee monthly until continued compliance of 90 percent or greater has been achieved for a minimum of six consecutive months where the numerator is the number of completed environment of care inspections in patient and non-patient care areas each month and the denominator is the total number of environment of care inspections due in patient and non-patient-care areas each month.

⁴⁴ VHA Directive 1608.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.⁴⁵ Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.⁴⁶ The suicide rate for veterans was higher than for nonveteran adults during 2020.⁴⁷ “Congress, VA, and stakeholders continue to express concern over seemingly limited progress made...to reduce veteran suicide.”⁴⁸

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.⁴⁹ 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.⁵⁰

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.⁵¹

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 34 patients who had a positive suicide screen in FY 2022 and received primary care services.

⁴⁵ VA Secretary memo, “Agency-Wide Required Suicide Prevention Training,” October 15, 2020.

⁴⁶ “Suicide Prevention: Facts about Suicide,” Centers for Disease Control and Prevention, accessed February 15, 2023.

⁴⁷ VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

⁴⁸ Congressional Research Service, “Veteran Suicide Prevention,” IF11886 version 2, July 29, 2021.

⁴⁹ 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.)

⁵⁰ 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.)

⁵¹ 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

VHA expects providers to complete the Comprehensive Suicide Risk Evaluation on the same day as a positive suicide risk screen in ambulatory care settings.⁵² The OIG found that providers did not complete the evaluation for 9 of 34 patients (26 percent) within the same day as the positive screen.⁵³ When providers fail to promptly evaluate patients' suicide risk, they could miss opportunities to coordinate next steps in care. The Chief of Primary Care acknowledged that primary care providers may be uncomfortable completing the evaluation due to concerns about not recognizing an issue and are inclined to hand off the patient to a mental health clinician. The Chief of Behavioral Health said some mental health providers may not complete the evaluation until the next day, believing they have 24 hours to do so.

Recommendation 3

3. The Medical Center Director ensures providers complete the Comprehensive Suicide Risk Evaluation the same day as a patient's positive suicide risk screen in ambulatory care settings.

⁵² 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)."

⁵³ Confidence intervals are not included because the data represents every patient in the study population.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Medical Center Director reviewed the recommendation and did not identify additional reasons for noncompliance. The Suicide Prevention Coordinator implemented several processes to ensure completion of Comprehensive Suicide Risk Evaluation the same day as a patient's positive suicide risk screen. Clinical Application Coordinators installed an automatic alert/reminder to the electronic medical record so that when a Veteran screens positive for suicide risk, the alert remains active until the Comprehensive Suicide Risk Evaluation has been completed. A report is pulled twice daily to identify any positive suicide risk screens that do not have a completed Comprehensive Suicide Risk Evaluation and the Suicide Prevention Coordinator follows up with identified practitioners to complete any missed Comprehensive Suicide Risk Evaluations. The Suicide Prevention Coordinator will report compliance monthly to the Executive Committee of the Medical Staff until compliance of 100 percent or greater has been reached for a minimum of six consecutive months. The numerator is the number of patients who had a comprehensive suicide risk evaluation completed the same day as their positive suicide screen each month. The denominator is the total number of patients who had a positive suicide screen each month.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided three 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 healthcare system. 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 three OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Medical Center Director and Chief of Staff. 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	<ul style="list-style-type: none"> None
Quality, Safety, and Value	<ul style="list-style-type: none"> None
Medical Staff Privileging	<ul style="list-style-type: none"> Practitioners from other facilities with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations for solo licensed independent practitioners.
Environment of Care	<ul style="list-style-type: none"> Staff conduct environment of care inspections in non-patient care areas at least once per fiscal year.
Mental Health: Suicide Prevention Initiatives	<ul style="list-style-type: none"> Providers complete the Comprehensive Suicide Risk Evaluation the same day as a patient's positive suicide risk screen in ambulatory care settings.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 2.¹

**Table B.1. Profile for VA Finger Lakes Healthcare System (528)
(October 1, 2019, through September 30, 2022)**

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	\$325,878,391	\$356,159,095	\$355,126,755
Number of:			
• Unique patients	30,625	34,121	34,540
• Outpatient visits	350,861	433,956	438,375
• Unique employees§	1,373	1,356	1,334
Type and number of operating beds:			
• Community living center	193	193	173
• Domiciliary	170	170	170
• Medicine	10	10	10
Average daily census:			
• Community living center	149	135	115
• Domiciliary	116	68	104
• Medicine	6	2	3

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).

¹ VHA medical facilities are classified according to a complexity model; a designation of “3” indicates a facility with “low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs.” VHA Office of Productivity, Efficiency & Staffing (OPES), “VHA Facility Complexity Model Fact Sheet,” October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 15, 2024

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

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

To: Director, Office of Healthcare Inspections (54CH06)

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

Thank you for the opportunity to review the draft report of the OIG Comprehensive Healthcare Inspection at VA Finger Lakes Healthcare System.

I have reviewed the medical center's plan to ensure compliance with the 3 identified recommendations and concur with them as submitted.

(Original signed by:)

JOAN E. MCINERNEY, MD, MBA, MA, FACEP
VISN 2 NETWORK DIRECTOR

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 12, 2024

From: Director, VA Finger Lakes Healthcare System (528)

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

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

Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the VA Finger Lakes Healthcare System.

I have reviewed and concur with the recommendations and will ensure the actions to correct the findings are completed and sustained as described in the responses. I appreciated the opportunity for this review as a continuing process to improve the care to our Veterans.

(Original signed by:)

Mr. Bruce Tucker
Medical Center Director
VA Finger Lakes Healthcare System

OIG Contact and Staff Acknowledgments

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