



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the Edith
Nourse Rogers Memorial
Veterans' Hospital in
Bedford, Massachusetts



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Figure 1. *Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts.*

Source: <https://vaww.va.gov/directory/guide/> (accessed January 21, 2021).

Abbreviations

ADNPCS	Associate Director Nursing and Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
FY	fiscal year
OIG	Office of Inspector General
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
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 Edith Nourse Rogers Memorial Veterans' Hospital in Bedford and three associated outpatient clinics in Massachusetts. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. COVID-19 pandemic readiness and response¹
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)²
5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
6. Care coordination (spotlighting inter-facility transfers)
7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual review of the Edith Nourse Rogers Memorial Veterans' Hospital during the week of January 25, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the hospital's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm,

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

² The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the Edith Nourse Rogers Memorial Veterans' Hospital because staff did not administer remdesivir during the review period.

the findings in this report may help this hospital and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG virtual review, the hospital's leadership team consisted of the Director, Chief of Staff, Associate Director Nursing and Patient Care Services, and Associate Director. Organizational communications and accountability were managed through a committee reporting structure, with Executive Board oversight of several working groups. Leaders monitored patient safety and care through the Quality, Safety, Value Committee, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the hospital's leaders had worked together for approximately eight months. The Associate Director Nursing and Patient Care Services, assigned in November 2014, had served on the team the longest. The newest members of the team, the Chief of Staff and Associate Director, were assigned in May 2020.

The OIG found the hospital average for the selected employee satisfaction survey leadership questions was similar to the VHA average. However, scores also indicated that the Chief of Staff has opportunities to improve employee attitudes towards leaders and the workplace, and the Associate Director Nursing and Patient Care Services could improve employee feelings about being treated with respect in their workgroup. Selected patient experience survey data indicated that patients appeared satisfied with the care provided. The results for male and female respondents were consistently more positive than VHA patients nationally.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosure of adverse patient events and did not identify any substantial organizational risk factors.³

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one

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

way to understand the similarities and differences between the top and bottom performers within VHA.⁴

In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. The executive leaders were also knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures, including Community Living Center SAIL measures, and should continue to take actions to sustain and improve performance.⁵

COVID-19 Pandemic Readiness and Response

The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this hospital and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

Mental Health

The OIG found the hospital generally complied with the completion of all required elements in the Columbia-Suicide Severity Rating Scale and suicide safety plans by the required staff. However, the OIG identified a deficiency with the completion of mandatory training by staff who develop suicide safety plans.

Care Coordination

The OIG observed general compliance with requirements for a facility policy addressing inter-facility transfers and monitoring and evaluation of inter-facility transfers. However, the OIG identified deficiencies with completion of all required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent (date and time transfer would occur, informed consent, medical and/or behavioral stability of the patient, mode of transportation, and identification of receiving physician); transmission of patients' active medication lists and advance directives to receiving facilities; and communication between nurses at sending and receiving facilities.

High-Risk Processes

The hospital met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with consistent attendance at Disruptive

⁴ "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020, <https://vssc.med.va.gov>. (This is an internal website not publicly accessible.)

⁵ VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. Community living centers, previously known as nursing home care units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.

Behavior Committee meetings and completion of prevention and management of disruptive behavior and Employee Threat Assessment Team trainings.

Conclusion

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

Comments

The Veterans Integrated Service Network Director and Hospital Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 53–54, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Edith Nourse Rogers Memorial Veterans' Hospital and the associated community-based clinics 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 hospital leaders so that informed decisions can be made to improve care.¹

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

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

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

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response⁵
3. Quality, safety, and value (QSV)

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

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

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

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

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

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

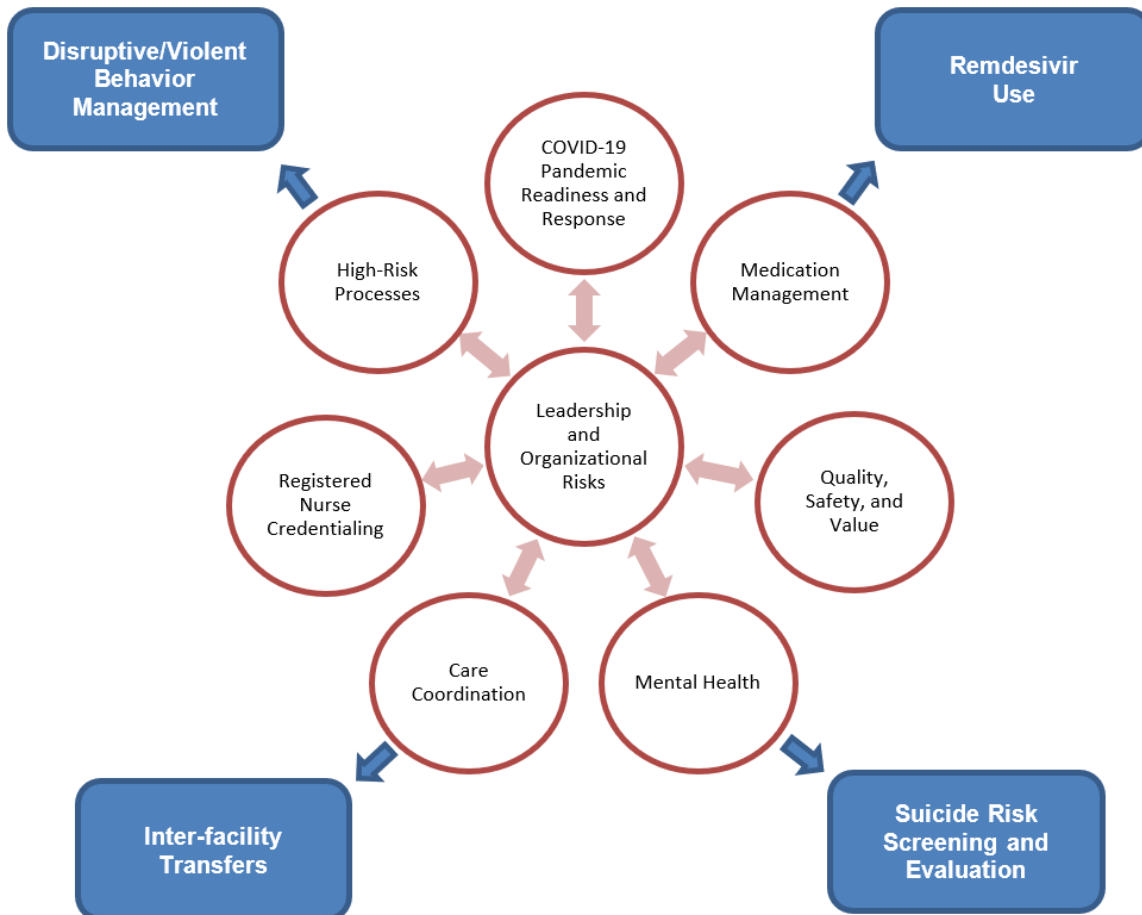


Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.

Source: VA OIG.

⁶ The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the Edith Nourse Rogers Memorial Veterans' Hospital because staff did not administer remdesivir during the review period.

Methodology

The Edith Nourse Rogers Memorial Veterans' Hospital also provides care through three outpatient clinics in Massachusetts. Additional details about the types of care provided by the hospital can be found in appendixes B and C.

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

The inspection examined operations from June 8, 2019, through January 29, 2021, the last day of the unannounced multiday evaluation.⁸ During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this hospital and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁹ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

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

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

⁹ Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

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

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

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

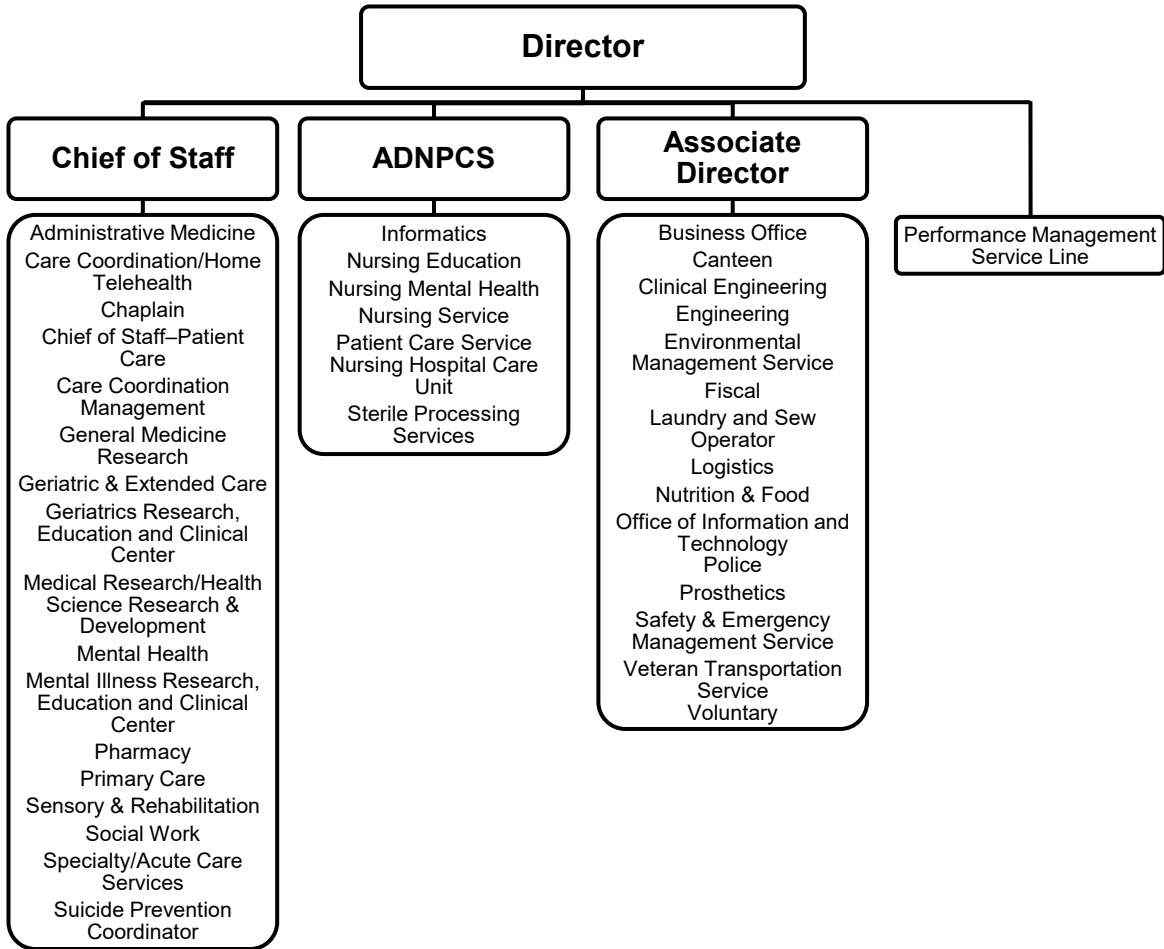


Figure 3. Hospital organizational chart.

Source: Edith Nourse Rogers Memorial Veterans' Hospital (received January 26, 2021).

At the time of the OIG inspection, the executive team had worked together for approximately eight months. The ADNPCS, assigned in November 2014, was the most tenured leader. The newest members, the Chief of Staff and Associate Director, were assigned in May 2020 (see table 1). The Director acknowledged that this change in leadership resulted in a team with a strong focus on servant leadership, employee satisfaction and engagement, and patient experience.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Hospital Director	March 18, 2018
Chief of Staff	May 24, 2020
Associate Director Nursing and Patient Care Services	November 2, 2014
Associate Director	May 10, 2020

Source: Edith Nourse Rogers Memorial Veterans' Hospital Human Resources Senior Strategic Business Partner (received January 25, 2021).

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

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, the executive leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The Director served as the chairperson of the Executive Board, which was responsible for the overall quality of care and operations at the hospital. The Executive Board oversaw the Health Care Delivery; Health Care Operations; Organizational Health; Quality, Safety, Value; and Strategic Planning Committees. These leaders monitored patient safety and care through the Quality, Safety, Value Committee, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

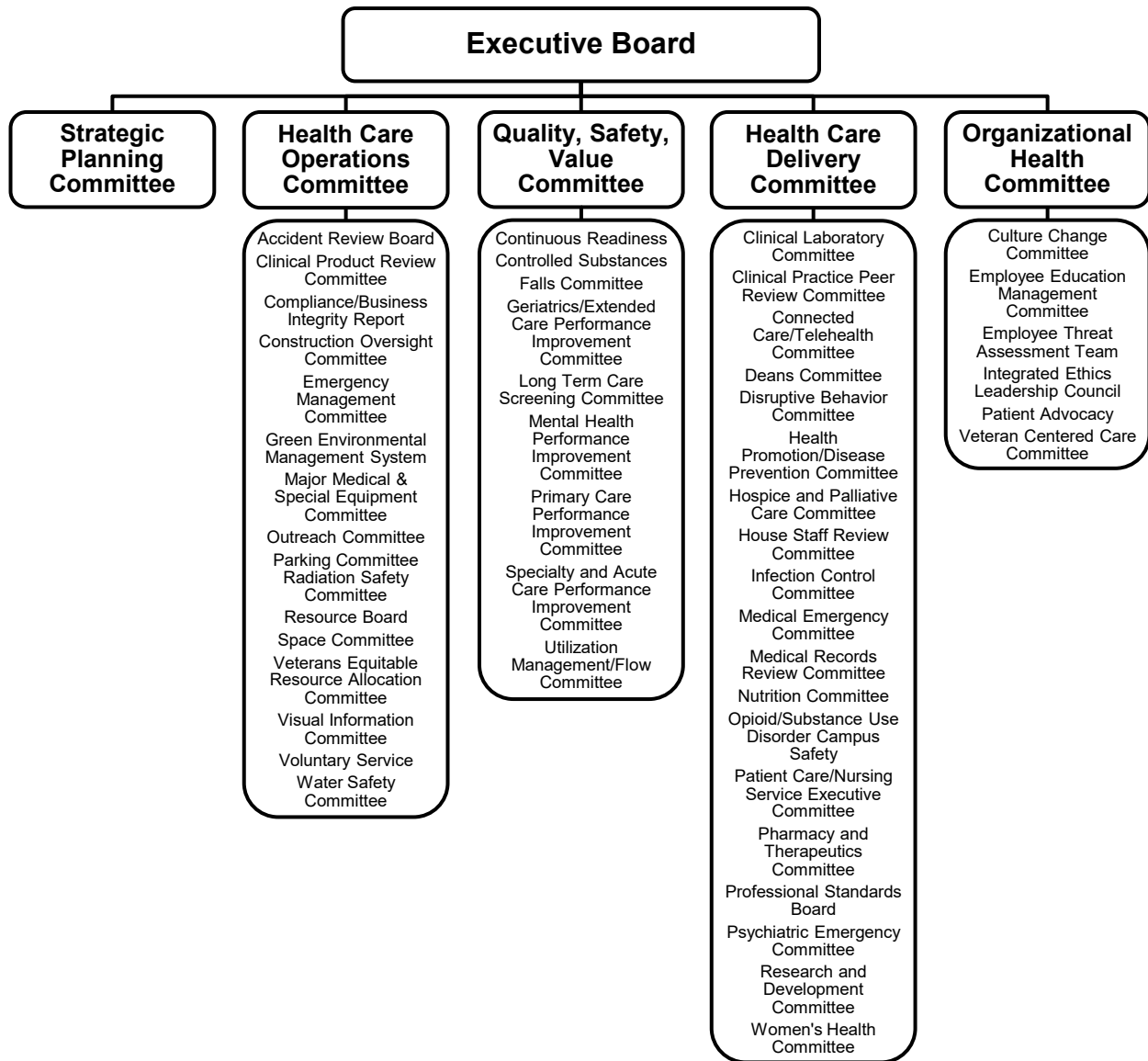


Figure 4. Hospital committee reporting structure.

Source: Edith Nourse Rogers Memorial Veterans' Hospital (received January 25, 2021).

Budget and Operations

The hospital's FY 2020 annual medical care budget of \$257,674,931 increased almost 15 percent compared to the previous year's budget of \$224,634,641.¹² When asked about the effect of this change on the hospital's operations, the Director indicated the increased budget enabled the hiring of more staff to meet higher patient demands during the pandemic, and despite the budget

¹² VHA Support Service Center.

increase, the Director reinforced that it is still important for hospital leaders to look for ways to be efficient.

Staffing

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

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.¹⁶ The executive leaders confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection. The Chief of Staff reported reviewing organizational charts, utilization scores, and efficiencies to determine if clinical positions or program restructuring were needed. Strategies implemented to alleviate challenges caused by provider staffing shortages included the consideration of dual appointments, collaboration with and increase in specialty services from VA Boston Healthcare System providers, and provision of telehealth appointments. The Associate Director spoke of recruiting and onboarding delays for custodial staff and how the hospital initiated a staffing contract for janitorial service during the COVID-19 pandemic.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortage
1. General Internal Medicine	1. Custodial Worker
2. Geriatrics	2. –
3. Primary Care	3. –
4. Psychiatry	4. –

Source: VA OIG.

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

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

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

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

Employee Satisfaction

The All Employee Survey “is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.” Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health.¹⁷ 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 hospital leaders.

To assess employee attitudes toward hospital leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey from October 1, 2019, through September 30, 2020.¹⁸ Table 3 provides relevant survey results for VHA, the hospital, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA’s All Employee Survey. The OIG found the hospital average for the selected survey leadership questions was similar to the VHA average.¹⁹ Scores related to the Director, ADNPCS, and Associate Director were consistently higher than those for VHA and the hospital. However, it appeared the Chief of Staff has opportunities to improve employee attitudes toward leaders. The Director spoke of employee satisfaction and engagement as a focus for leaders this year. The Director also reported the past year was challenging but made the hospital stronger because staff pulled together as never seen before. For example, non-frontline staff joined together to provide food, supportive phone calls, and assistance to the frontline staff. Additionally, after learning about staff sleeping in garages at home or in cars in the hospital parking lot due to fear of spreading COVID-19 to family members, the Director opened a lodging space for staff on campus. Providing a safe space for staff to stay during off-hours helped to reduce the possibility of spreading the virus and ensured that staff had a safe place to rest between shifts.

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

¹⁸ Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADNPCS, and Associate Director.

¹⁹ The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

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

Questions/ Survey Items	Scoring	VHA Average	Hospital Average	Director Average	Chief of Staff Average	ADNPCS Average	Assoc. Director Average
All Employee Survey: <i>Servant Leader Index Composite.*</i>	0–100 where higher scores are more favorable	73.5	74.2	81.0	73.2	79.0	86.1
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.4	3.4	4.0	3.1	3.7	4.1
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	4.2	3.2	3.7	4.2
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	4.4	3.3	4.0	4.4

Source: VA All Employee Survey (accessed December 21, 2020).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.²⁰ The hospital average for the selected survey questions was similar to the VHA average. Scores for the Director, ADNPCS, and Associate Director were similar to or better than those for VHA and the hospital. However, it appeared the Chief of Staff also has opportunities to improve employee attitudes towards the workplace.

²⁰ Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADNPCS, and Associate Director.

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

Questions/Survey Items	Scoring	VHA Average	Hospital Average	Director Average	Chief of Staff Average	ADNPCS Average	Assoc. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	4.6	3.3	3.9	4.6
All Employee Survey: <i>Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	4.2	3.6	3.6	4.2
All Employee Survey: <i>In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?</i>	0 (Never)–6 (Every Day)	1.4	1.6	1.4	2.3	1.5	1.3

Source: VA All Employee Survey (accessed December 21, 2020).

VHA leaders have articulated that the agency “is committed to a harassment-free healthcare environment.” To this end, leaders initiated the “End Harassment” and “Stand Up to Stop Harassment Now!” campaigns to help create a culture of safety where staff and patients feel secure and respected.²¹

The leaders spoke of ongoing efforts to create a harassment-free healthcare environment. For example, the hospital implemented a Harassment Team and Diversity, Inclusion, Equity and Tolerance group. The leaders described the Harassment Team as a non-disciplinary proactive

²¹ “Stand Up to Stop Harassment Now!” Department of Veterans Affairs, accessed December 8, 2020, <https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/>. Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

group tasked with evaluating situations and reporting their findings to leaders. The leaders then review the information, identify trends, and determine responses to each situation. The hospital recently implemented bystander intervention training to help staff identify and stop harassment. The leaders said the Diversity, Inclusion, Equity and Tolerance group elevates issues to leaders and helps create opportunities for staff to obtain the skills needed to advance.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. Scores related to the Director and Associate Director were notably better than those for VHA and the hospital. However, the Chief of Staff and ADNPCS have opportunities to improve employees' feelings about tolerance of discrimination in the workplace and respectful treatment within workgroups, respectively.

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

Questions/Survey Items	Scoring	VHA Average	Hospital Average	Director Average	Chief of Staff Average	ADNPCS Average	Assoc. Director Average
All Employee Survey: <i>People treat each other with respect in my workgroup.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	3.9	4.2	3.9	3.5	4.6
All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	4.0	4.0	4.6	3.8	4.2	4.3
All Employee Survey: <i>Members in my workgroup are able to bring up problems and tough issues.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.8	4.4	3.7	3.7	4.3

Source: VA All Employee Survey (accessed December 21, 2020).

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to two relevant outpatient survey questions that reflect patients' attitudes toward their healthcare experiences.²² Table 6 provides relevant survey results for VHA and the hospital.²³ For this hospital, the overall patient satisfaction survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	Hospital Average
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	88.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	88.4

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.²⁴ For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Patient-Centered Medical Home and Specialty Care surveys (see tables 7 and 8). The results for male and female respondents were consistently higher than corresponding VHA averages. Leaders seem to be actively engaged with male and female patients. For example, leaders conducted listening sessions with women veterans and used the Veterans Signals Survey to learn about their experiences.

²² The hospital does not provide medical/surgical inpatient care; therefore, related data are not available.

²³ Ratings are based on responses by patients who received care at this hospital.

²⁴ "Veteran Population," Table 1L: VetPop2018 Living Veterans by Age Group, Gender, 2018-2048, National Center for Veterans Analysis and Statistics, accessed November 30, 2020, https://www.va.gov/vetdata/Veteran_Population.asp.

Table 7. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Hospital	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	61.2	— [‡]
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	72.8	66.7
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	80.1	74.2

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

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

The hospital averages are based on 172–667 male and 7–27 female respondents, depending on the question.

[‡]Due to low number of respondents, there were no data available.

**Table 8. Specialty Care Survey Results on Patient Experiences by Gender
(October 1, 2019, through September 30, 2020)**

Questions	Scoring	VHA*		Hospital	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	52.4	58.4
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	62.0	88.1
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	77.9	91.6

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

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

The hospital averages are based on 198–670 male and 11–36 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.²⁵ Table 9 summarizes the relevant hospital inspection most recently performed by the OIG. At the time of the OIG review, the hospital had 12 open recommendations for improvement issued from the previous CHIP site visit conducted in June 2019. In individual interviews, the Director and Director of Performance Management were able to speak knowledgeably about the status of

²⁵ “Profile Definitions and Methodology: Joint Commission Accreditation,” American Hospital Directory, accessed December 12, 2020, https://www.ahd.com/definitions/prof_accred.html. “The Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.”

improvement actions, and the Director of Performance Management reported achieving compliance but needing more time to demonstrate sustained improvement.

The OIG team also noted the hospital's accreditation by the Long Term Care Institute.²⁶

Table 9. Office of Inspector General Inspection

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts, Report No. 19-00043-66, January 13, 2020</i>)	June 2019	21	12*

Source: OIG.

*As of August 2021, five recommendations remained open.

Identified Factors Related to Possible Lapses in Care and Hospital Responses

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

²⁶ "About Us," Long Term Care Institute, accessed December 8, 2020, <http://www.ltcior.org/about-us/>. The Long Term Care Institute is "focused on long-term care quality and performance improvement, compliance program development, and review in long-term care, hospice, and other residential care settings."

Table 10 lists the reported patient safety events from June 3, 2019 (the prior OIG CHIP site visit), through January 24, 2021.²⁷

Table 10. Summary of Selected Organizational Risk Factors (June 3, 2019, through January 24, 2021)

Factor	Number of Occurrences
Sentinel Events	1
Institutional Disclosures	1
Large-Scale Disclosures	0

Source: Edith Nourse Rogers Memorial Veterans' Hospital Risk Manager and Patient Safety Manager (received January 25 and 26, 2021).

The Director spoke knowledgeably about serious adverse event reporting and the process for all adverse events being reported at the Director's daily morning huddle. After reviewing the adverse events, the leaders discussed if corrective actions were required for each event. Through the Quality, Safety, Value Committee, corrective actions were tracked to closure. The OIG did not identify areas of concern related to accreditation, sentinel events, or disclosures.

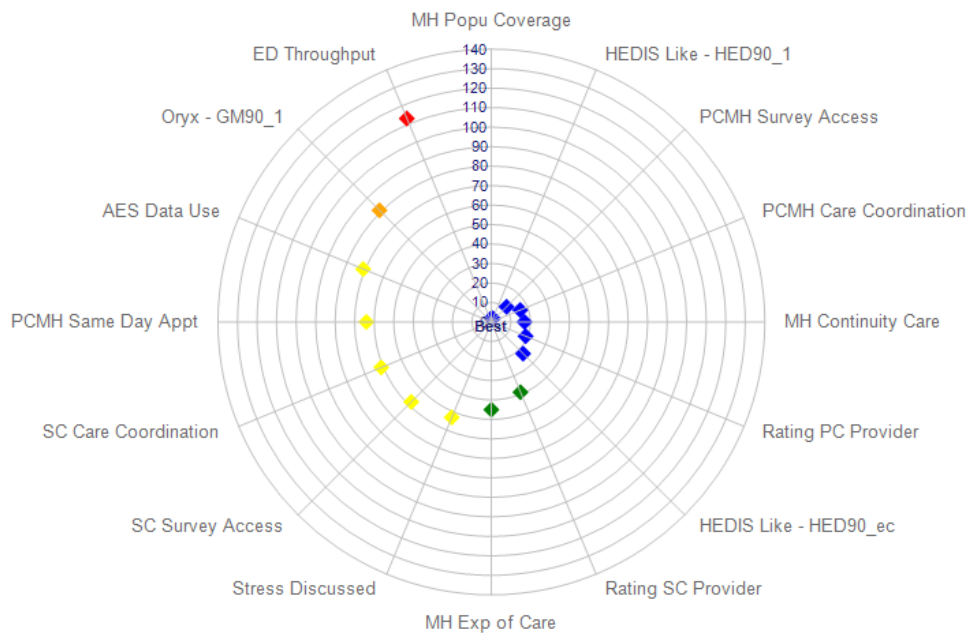
Veterans Health Administration Performance Data for the Hospital

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” Despite noted limitations for identifying all areas of

²⁷ It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The Edith Nourse Rogers Memorial Veterans' Hospital is a low complexity (3) affiliated facility as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.” Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.” Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.”

clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.²⁸

Figure 5 illustrates the hospital's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the hospital's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of mental health (MH) population (popu) coverage, mental health (MH) continuity (of) care, and rating (of) specialty care (SC) provider). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (ORYX inpatient composite of global measures (Oryx GM 90_1) and emergency department (ED) throughput).²⁹



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

Figure 5. Hospital quality of care and efficiency metric rankings (as of June 30, 2020).

Source: VHA Support Service Center.

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

²⁸ "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020, <https://vssc.med.va.gov>. (This is an internal website not publicly accessible.)

²⁹ For information on the acronyms in the SAIL metrics, please see appendix E.

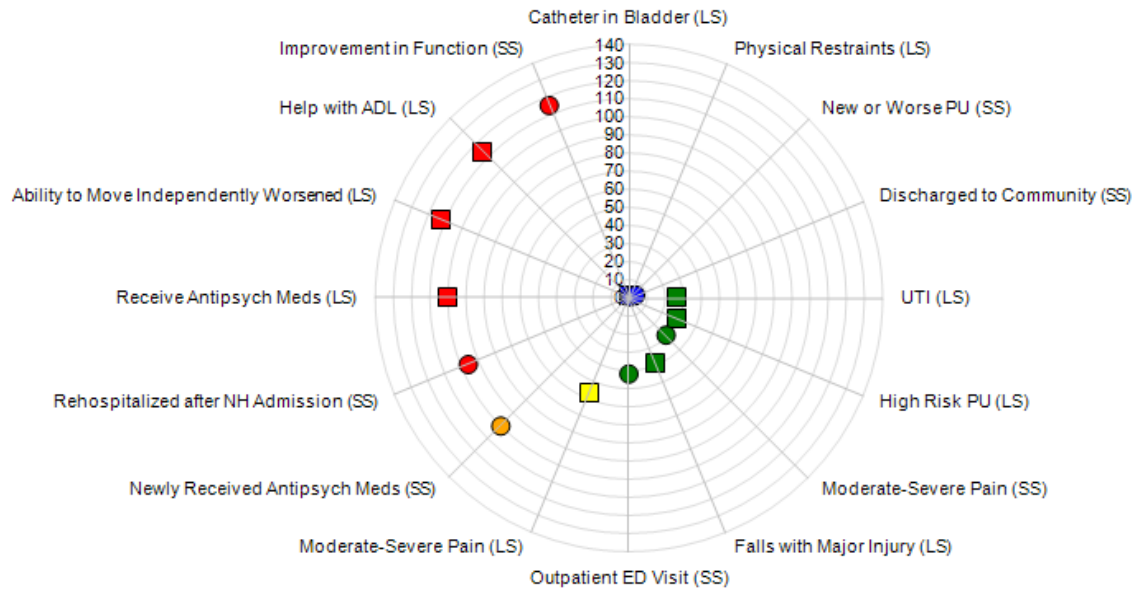
Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to “summarize and compare performance of CLCs in the VA.” The model “leverages much of the same data” used in the Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare* and provides a single resource “to review quality measures and health inspection results.”³⁰

Figure 6 illustrates the hospital’s CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the Edith Nourse Rogers CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of catheter in bladder–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and urinary tract infections (UTI)(LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, newly received antipsych meds (SS), ability to move independently worsened (LS), and help with activities of daily living (ADL) (LS)).³¹

³⁰ Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, July 23, 2020. “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

³¹ For data definitions of acronyms in the SAIL CLC measures, please see appendix F.



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

Figure 6. Edith Nourse Rogers CLC quality measure rankings (as of June 30, 2020).

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

At the time of the virtual review, the executive team had worked together for approximately eight months. The ADNPCS, assigned in November 2014, had served on the team the longest. The newest members of the team, the Chief of Staff and Associate Director, were assigned in May 2020.

The OIG found the hospital average for the selected employee satisfaction survey leadership questions was similar to the VHA average. However, scores also indicated that Chief of Staff has opportunities to improve employee attitudes towards leaders and the workplace, and the ADNPCS could improve employees' feelings about being treated with respect in their workgroups. Selected patient experience survey data indicated that patients appeared satisfied with the care provided. The results for male and female respondents were consistently more positive than VHA patients nationally.

The OIG's review of the hospital's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models and should continue to take actions to sustain and improve performance.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the “alarming levels of spread and severity” of COVID-19, the World Health Organization declared a pandemic.³² VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.³³

During this time, VA continued providing care to veterans and engaged its fourth mission, the “provision of hospital care and medical services during certain disasters and emergencies” to persons “who otherwise do not have VA eligibility for such care and services.”³⁴ “In effect, VHA facilities provide a safety net for the nation’s hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans.”³⁵

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

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

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

The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this hospital and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

³² “WHO Director-General’s Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020,” World Health Organization, accessed December 8, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

³³ VHA Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

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

³⁵ VA OIG, *OIG Inspection of Veterans Health Administration’s COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.³⁶ To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.³⁷ Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."³⁸

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

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

The OIG reviewers also assessed the hospital's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization." Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."³⁹ The OIG team examined various requirements related to systems redesign and improvement:

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

³⁶ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

³⁷ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

³⁸ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

³⁹ VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Next, the OIG assessed the hospital's processes for conducting protected peer reviews of clinical care.⁴⁰ Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."⁴¹ Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.⁴² The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit⁴³
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews⁴⁴
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed VHA facilities' compliance with selected surgical program requirements. The OIG did not conduct the review at the Edith Nourse Rogers Memorial Veterans' Hospital because the hospital did not have a surgical program.

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, and other relevant information.⁴⁵

⁴⁰ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. § 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

⁴¹ VHA Directive 1190.

⁴² VHA Directive 1190.

⁴³ VHA Directive 1190.

⁴⁴ VHA Directive 1190. A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently."

⁴⁵ For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

Quality, Safety, and Value Findings and Recommendations

Generally, the hospital met the above requirements. The OIG made no recommendations.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of “professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate.”⁴⁶ Licensure is defined by VHA as “the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration.”⁴⁷

VA requires all RNs to hold at least one active, unencumbered license.⁴⁸ Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.⁴⁹ When an action has been “taken against [an] applicant’s sole license or against any of the applicant’s licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA’s licensure requirements,” and documented as required.⁵⁰ Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA’s electronic credentialing system, prior to appointment to a VA medical facility.⁵¹

The OIG assessed compliance with VA licensure requirements by conducting interviews with key employees and managers and reviewing relevant documents for 25 RNs hired from January 1 through December 20, 2020. The OIG determined whether

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

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

⁴⁶ VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

⁴⁷ VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

⁴⁸ VHA Directive 2012-030. “Definition of *Unencumbered license*,” Law Insider, accessed December 3, 2020, <https://www.lawinsider.com/dictionary/unencumbered-license>. An unencumbered license is “a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action.”

⁴⁹ 38 U.S.C. § 7402.

⁵⁰ VHA Directive 2012-030.

⁵¹ VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.⁵² The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.⁵³ However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.⁵⁴

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.⁵⁵ The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.⁵⁶ The hospital was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

⁵² “Preventing Suicide,” Centers for Disease Control and Prevention, accessed December 9, 2020, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

⁵³ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.

⁵⁴ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.

⁵⁵ Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018.

⁵⁶ DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

- the electronic health records of 41 randomly selected patients who were seen in the urgent care center from December 1, 2019, through August 31, 2020; and⁵⁷
- staff training records.

Mental Health Findings and Recommendations

The OIG found the hospital generally complied with the completion of all required elements in the Columbia-Suicide Severity Rating Scale and suicide safety plans by the required staff. However, the OIG identified a deficiency with the completion of mandatory training by staff who develop suicide safety plans.

VHA requires staff to complete mandatory suicide safety plan training prior to developing suicide safety plans with patients.⁵⁸ The OIG found that 8 of 29 staff responsible for suicide safety plan development had not completed the mandatory training.⁵⁹ Lack of staff training may lead to inadequate safety planning with patients who are at risk for suicide. The Mental Health Service Line Manager reported not being aware of the training requirement until the VISN sent out a notification at the end of November 2020. The Mental Health Service Line Manager further explained that the notification had unclear requirements. After seeking clarification, the manager assigned the course to the required staff with a three-week timeframe for completion.

Recommendation 1

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

⁵⁷ The Edith Nourse Rogers Memorial Veterans' Hospital does not have an emergency department.

⁵⁸ DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

⁵⁹ DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*.

Hospital concurred.

Target date for completion: January 31, 2022

Hospital response: As a result of the OIG recommendation, all staff responsible for suicide safety planning in the urgent care department have now completed suicide safety planning education.

Training was completed January 31, 2021.

There have been no additional hires in that department since that date. The Chief of Social Services has validated the completion of suicide safety planning education for all the MH staff at VA Bedford.

The education is documented, and a list can be pulled from the VA talent management system. For new staff, the urgent care nurse manager has added suicide safety planning education to the clinical orientation checklist on the unit. For staff from another department who may work in urgent care, the creation of a suicide safety plan will be delegated to an urgent care staff member who has undergone suicide safety planning education. Going forward, the nurse manager for urgent care will report any new staff requiring suicide safety planning education to the Performance Management service line each month. Success will be measured at 90% compliance over six consecutive months. Oversight of this process will be done through monthly reporting to the Quality, Safety and Value committee.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.⁶⁰

VHA medical facility directors are “responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients.” Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.⁶¹

The hospital was assessed for its adherence to various requirements:

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

To determine whether the hospital complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 44 patients who were transferred from the hospital due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The OIG observed general compliance with requirements for a facility policy addressing inter-facility transfers and monitoring and evaluation of inter-facility transfers. However, the OIG identified deficiencies with completion of all required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent (date and time transfer would occur, informed consent, medical and/or behavioral stability of the patient, mode of transportation, and identification of

⁶⁰ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁶¹ VHA Directive 1094. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients’ informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

receiving physician); transmission of patients' active medication lists and advance directives to receiving facilities; and communication between nurses at sending and receiving facilities.

VHA requires that the hospital Chief of Staff and ADNPCS ensure referring physicians record “[t]he date and time transfer will occur...[d]ocumentation of the patient’s (or legally-responsible person acting on the patient's behalf) informed consent to transfer...[m]edical and/or behavioral stability of the patient for transfer...[t]he mode of transportation and equipment needed...[and] [i]dentification of the transferring and receiving physicians.”⁶² For the electronic health records reviewed, the OIG estimated that

- 32 percent did not include the date and time the transfer would occur,⁶³
- 66 percent did not address the patient’s or legally responsible person’s informed consent,⁶⁴
- 48 percent did not address the patient’s medical and/or behavioral stability,⁶⁵
- 32 percent did not include the mode of transportation,⁶⁶ and
- 77 percent did not identify the receiving physician.⁶⁷

These deficiencies could result in the unsafe transfer of patients, the inability to monitor and evaluate transfer data, and an incomplete medical record. The Urgent Care Medical Director reported competing patient care priorities (stabilizing the patient for transfer), minimal staff after hours, and prioritization of progress note completion instead of the VA *Inter-Facility Transfer Form* as reasons for noncompliance. In addition, the Utilization Management/Patient Flow Committee Chair reported that mental health providers do not transfer patients often and were unaware of the inter-facility transfer documentation requirements.

⁶² VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁶³ The OIG estimated that 95 percent of the time, the true compliance rate is between 54.35 and 81.82 percent, which is statistically significantly below the 90 percent benchmark.

⁶⁴ The OIG estimated that 95 percent of the time, the true compliance rate is between 20.45 and 48.78 percent, which is statistically significantly below the 90 percent benchmark.

⁶⁵ The OIG estimated that 95 percent of the time, the true compliance rate is between 37.50 and 67.39 percent, which is statistically significantly below the 90 percent benchmark.

⁶⁶ The OIG estimated that 95 percent of the time, the true compliance rate is between 54.35 and 81.39 percent, which is statistically significantly below the 90 percent benchmark.

⁶⁷ The OIG estimated that 95 percent of the time, the true compliance rate is between 11.11 and 35.72 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 2

2. The Chief of Staff and Associate Director Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure that the referring physician completes all required elements of the VA *Inter-Facility Transfer Form* or facility-defined equivalent prior to patient transfer.

Hospital concurred.

Target date for completion: December 31, 2021

Hospital response: In response to the OIG recommendation, VA Bedford has created a template using mandatory fields in CPRS [Computerized Patient Record System] with all required elements of safe transfers. The changes that were made include: Combining 2 physician transfer notes into one, the creation of a post transfer checklist, provision of staff education and the development of a post transfer checklist. In addition, we are expecting a new VISN 1 CPRS interfacility transfer template covering all necessary components that is in the approval stage of implementation. We will implement that template and provide the accompanying template education as soon as it is approved. To monitor compliance with the recommendation for completeness of interfacility transfer documentation, every transfer patient's chart will be audited to determine if date and time, patient condition, mode of transportation, name of the receiving physician and informed consent were addressed. Success will be measured at 90% compliance through audits of all transfers over a 6-month span of time. Progress will be reported to the Quality, Safety and Value Committee each month.

VHA requires the hospital Chief of Staff and ADNPCS to ensure that “all pertinent medical records available, including an active patient medication list and any medications given to the patient prior to transfer [be sent] with the patient, including documentation of the patient's advance directive made prior to transfer, if any.”⁶⁸ The OIG estimated that 66 percent of electronic health records lacked evidence that staff sent the active medication list to the receiving facility.⁶⁹ Further, the OIG determined that for the 22 patients with an advance directive, there was no evidence that staff sent a copy of it to the receiving facility. Failure to send pertinent medical records could result in incorrect treatment decisions that may compromise patient safety. The Medical Director of Urgent Care stated that staff sent a packet of transferring documents, including this information, with the patient at transfer. However, the OIG did not find evidence of this in the electronic health records reviewed.

⁶⁸ VHA Directive 1094.

⁶⁹ The OIG estimated that 95 percent of the time, the true compliance rate is between 20.83 and 48.78 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 3

3. The Chief of Staff and Associate Director Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure that staff send all pertinent medical records to the receiving facility during inter-facility transfers.

Hospital concurred.

Target date for completion: December 31, 2021

Hospital response: VA Bedford recognizes the importance and safety of providing patients' advanced directives and an updated medication list during transitions of care. Education has been provided to all medical staff involved in patient transfers and the advanced directive and med list have been added to the patient transfer note and transfer checklist which goes with every patient transferring out. In addition, the components of a full medication list and advanced directives have been added to a new VISN 1 CPRS template for interfacility transfers that will be implemented as soon as it is approved by committee. Success will be measured at 90% compliance through monthly chart audits over a 6-month span of time. Compliance will be monitored through monthly reports to the Quality, Safety and Value Committee.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at both sending and receiving facilities.⁷⁰ The OIG did not find evidence of this communication in an estimated 70 percent of inter-facility transfers.⁷¹ This could result in staff at the receiving facility lacking the information needed to care for patients. The Nurse Manager of Specialty and Acute Care reported that because nurses rushed to facilitate the patient transfer, documenting nurse communication was overlooked.

Recommendation 4

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

⁷⁰ VHA Directive 1094.

⁷¹ The OIG estimated that 95 percent of the time, the true compliance rate is between 16.67 and 43.19 percent, which is statistically significantly below the 90 percent benchmark.

Hospital concurred.

Target date for completion: December 31, 2021

Hospital response: VA Bedford recognizes the importance of nurse to nurse communication as a component of safe patient transitions of care. In response to the OIG's recommendation, a new template for nursing transfer notes that includes nurse to nurse communication has been developed in CPRS. All nursing staff involved in interfacility transfers have been provided education about the importance of documenting nurse to nurse communication as this is a component and further assurance of patient safety. Feedback on completion of communication will be provided to nurses formatively through chart audits. Success will be measured at 90% compliance through monthly CPRS audits of every transfer over a 6-month span of time. Compliance with this performance metric will be monitored through monthly reports to the Quality, Safety and Value Committee.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as “behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility.”⁷² Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has “committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety.”⁷³ The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team⁷⁴
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings⁷⁵
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction⁷⁶
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants⁷⁷

⁷² VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

⁷³ VHA Directive 2012-026.

⁷⁴ VHA Directive 2012-026. An employee threat assessment team is “a facility-level, interdisciplinary team whose primary charge is using evidence-based and data-driven practices for addressing the risk of violence posed by employee-generated behavior(s), that are disruptive or that undermine a culture of safety.”

⁷⁵ VHA Directive 2012-026. VHA defines a disruptive behavior committee or board as “a facility-level, interdisciplinary committee whose primary charge is using evidence-based and data-driven practices for preventing, identifying, assessing, managing, reducing, and tracking patient-generated disruptive behavior.”

⁷⁶ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018. VA requires each medical facility’s disruptive behavior committee “to use the Disruptive Behavior Reporting System (DBRS) to document a decision to implement an Order of Behavioral Restriction (OBR) and to document notification of a patient when an OBR is issued.”

⁷⁷ DUSHOM Memorandum, *Workplace Behavioral Risk Assessment (WBRA)*, October 19, 2012. The Workplace Behavioral Risk Assessment is a “data-driven process that evaluates the unique constellation of factors that affect workplace safety. It enables facilities to make informed, supportable decisions regarding the level of PMDB [Prevention and Management of Disruptive Behavior] training needed to sustain a culture of safety in the workplace.”

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.⁷⁸ VHA also requires that employee threat assessment team members complete the appropriate team-specific training.⁷⁹ The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The hospital generally complied with the establishment of a local policy for reporting and tracking disruptive behavior, implementation of the Employee Threat Assessment Team and Disruptive Behavior Committee, use of the Disruptive Behavior Reporting System, and completion of the Workplace Behavioral Risk Assessment. However, the OIG identified deficiencies with consistent attendance at Disruptive Behavior Committee meetings and completion of prevention and management of disruptive behavior and Employee Threat Assessment Team trainings.

VHA requires facilities' clinical executives (Chief of Staff and ADNPCS) to establish a disruptive behavior committee or board that includes a senior clinician chairperson, clerical and administrative support staff, patient advocate, and representation from the Prevention Management of Disruptive Behavior Program, patient safety and/or risk management, VA police, and Union Safety Committee.⁸⁰ The OIG reviewed Disruptive Behavior Committee attendance for 12 meetings held from July 17 through December 18, 2020. The OIG found that clerical and administrative support staff did not attend any meetings; the Patient Advocate did not attend 9 (75 percent) meetings; and representatives from the Prevention Management of Disruptive Behavior Program, patient safety and/or risk management, and VA police did not attend 6 (50 percent), 4 (33 percent), and 2 (17 percent) meetings, respectively.⁸¹ This could have

⁷⁸ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

⁷⁹ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

⁸⁰ VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

⁸¹ The Union Safety Committee representative also did not attend but was not included in the finding based on *Executive Order Ensuring Transparency, Accountability, and Efficiency in Taxpayer Funded Union Time Use*, issued May 25, 2018.

resulted in a lack of knowledge and expertise when assessing patients' disruptive behavior. The Disruptive Behavior Committee acting chair reported assuming the role on January 4, 2021, and was not aware of the requirement. Additionally, the acting chair acknowledged awareness of the directive but referred to the local charter, which did not identify required committee members. The acting chair also stated that discrepancies between the charter and directive were not identified because the charter was updated using only the previous charter.

Recommendation 5

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

Hospital concurred.

Target date for completion: January 31, 2022

Hospital response: VA Bedford recognizes the importance of subject matter experts and consistent attendance at disruptive behavior committee (DBC) meetings to the provision of the safest patient care possible. The DBC has revised its charter to include a clinician chairperson, clerical support staff, patient advocate, a representative of the Prevention and Management of Disruptive Behavior (PMDB) program, patient safety and/or risk management, VA police and a Union Committee member. In addition, attendance of the above required members will be audited through submission of committee minutes to the Performance Management service line for 6 months to gauge compliance. Oversight will be accomplished through monthly reporting to the Quality, Safety and Value Committee. Success will be measured by compliance at 90% over 6 consecutive months.

As noted in the requirements above, each VHA facility must ensure that employees complete prevention and management of disruptive behavior training based on risk level of their work location.⁸² The OIG found that 20 of 30 employees had not been scheduled for or completed the required trainings. This could result in employees' lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Associate Chief Nurse for Education stated the hospital had a moratorium on in-person trainings due to the pandemic, which resulted in new employees not completing training in the required time frame. Additionally, the Talent Manager System Domain Manager explained that, due to a change in training requirements and inaccurate employee information, some employees were not assigned the training based on the risk level assigned to their work area.

⁸² DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

Recommendation 6

6. The Hospital Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

Hospital concurred.

Target date for completion: January 31, 2022

Hospital response: VA Bedford recognizes the need for timely disruptive behavior training to optimize employee safety. The PMBD coordinator will provide levels 1, 2a, 2b and level 3 training based on an individual employee's risk within 90 days of hire. A report will be run in TMS [Talent Management System] each month with a goal of 90% timely completion over 6 consecutive months. Compliance will be reported to the DBC at each meeting and tracked by the Performance Management service line. Compliance oversight will be accomplished through reporting to the Healthcare Delivery and Quality, Safety and Value Committees monthly.

VHA requires members of the Employee Threat Assessment Team to complete specific workplace violence prevention program training.⁸³ The OIG found that three of eight team members did not complete the required training. Lack of training may result in failure to recognize, evaluate, and manage the risk of future violence. The Chair of the Employee Threat Assessment Team reported assuming the role in May 2020 and was not aware of the training requirement. The co-chair stated that most members had been in place since the team's creation and had fulfilled the training requirements at that time. The co-chair indicated that new team members verbally reported training completion but there was not a formal validation process.

Recommendation 7

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

⁸³ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

Hospital concurred.

Target date for completion: January 31, 2022

Hospital response: VA Bedford recognizes the importance of each member of the Employee Threat Assessment Team [ETAT] completing the required workplace violence prevention program training. Education for all current members of the committee was completed by January 31, 2021. The committee charter will be revised to include the requirement for ETAT training prior to attending a committee meeting and will be stated in the appointment letter for each new member to ensure the training occurs. Reporting of the appointment of new members will be reported to the Performance Management service line each month. Compliance will be reported to the Quality, Safety and Value committee monthly with a goal of 90% for success.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines seven OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and ADNPCS. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

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

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

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

Appendix B: Hospital Profile

The table below provides general background information for this low complexity (3) affiliated facility reporting to VISN 1.¹

**Table B.1. Profile for Edith Nourse Rogers Memorial Veterans' Hospital (518)
(October 1, 2017, through September 30, 2020)**

Profile Element	Facility Data FY 2018*	Facility Data FY 2019	Facility Data FY 2020‡
Total medical care budget	\$214,763,017	\$224,634,641	\$257,674,931
Number of:			
• Unique patients	19,424	19,618	19,015
• Outpatient visits	217,484	213,860	201,601
• Unique employees§	1,162	1,195	1,191
Type and number of operating beds:			
• Community living center	304	240	240
• Domiciliary	56	56	56
• Mental health	48	48	48
• Residential rehabilitation	42	42	42
Average daily census:			
• Community living center	184	218	203
• Domiciliary	45	37	38
• Mental health	31	30	26
• Residential rehabilitation	31	31	20

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

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

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

October 1, 2018, through September 30, 2019.

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

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

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

Appendix C: VA Outpatient Clinic Profiles

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

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

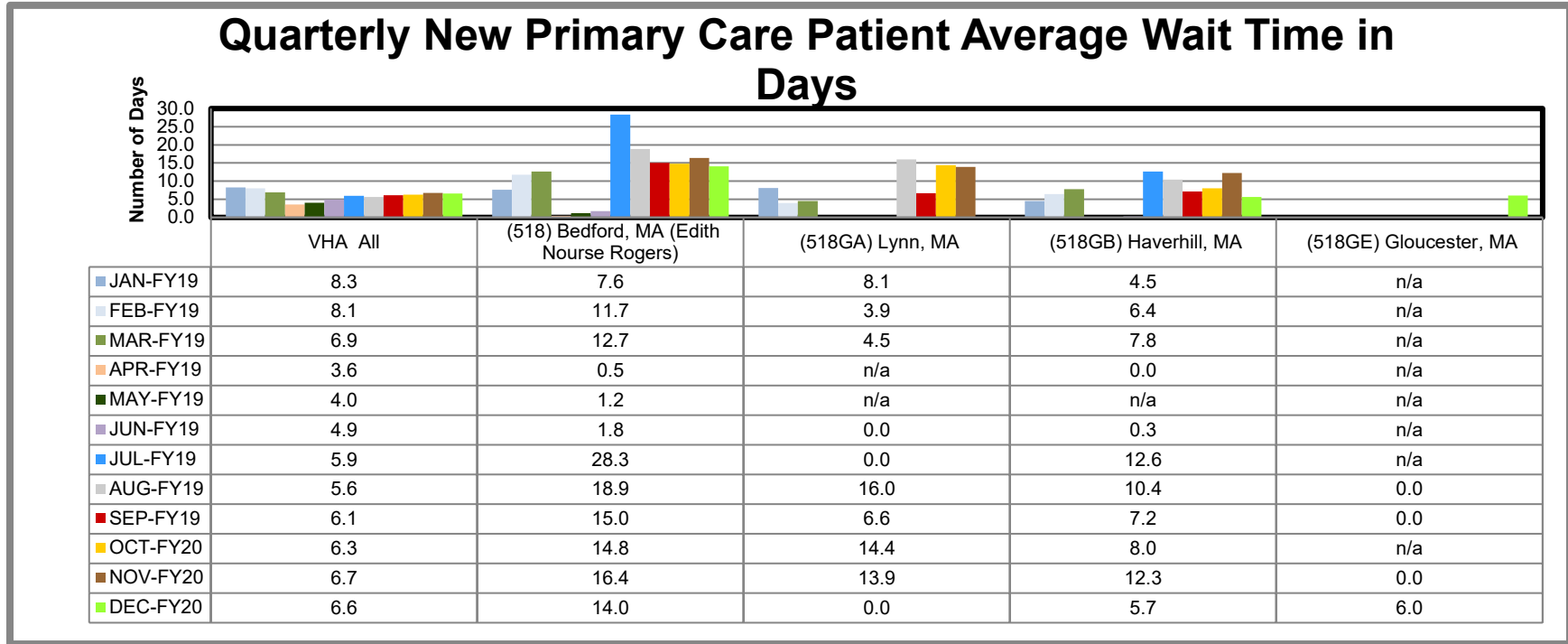
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Lynn, MA	518GA	2,090	1,065	Anesthesia	EKG	Nutrition Weight management
Haverhill, MA	518GB	3,340	756	Anesthesia Dermatology	EKG	Nutrition Weight management
Gloucester, MA	518GE	1,900	291	Anesthesia	EKG	Nutrition Weight management

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

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

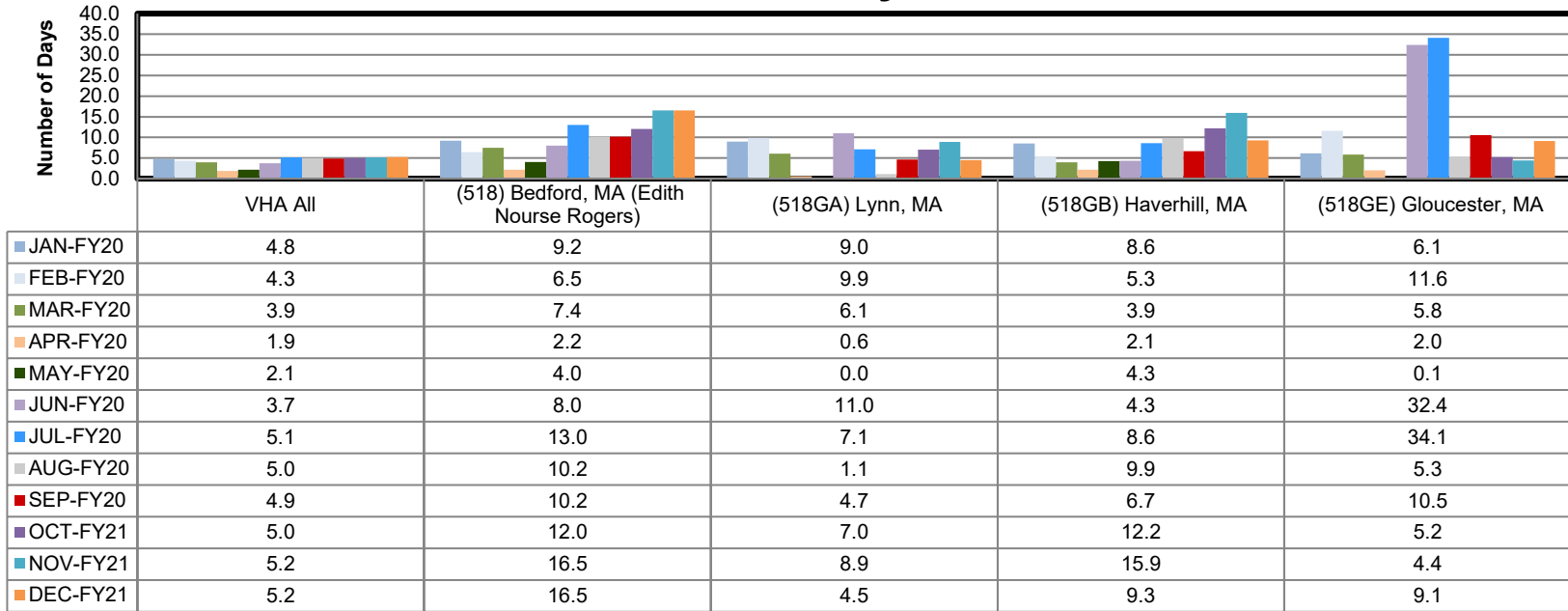


Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, <https://vssc.med.va.gov>, accessed October 21, 2019.

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

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

Quarterly Established Primary Care Patient Average Wait Time in Days



Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, <https://vssc.med.va.gov>, accessed October 21, 2019.

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the hospital's explanation for the increased wait times for the Gloucester, Massachusetts clinic.

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

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

Measure	Definition	Desired Direction
AES Data Use	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HEDIS like – HED90_1	Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient behavioral health screening, prevention, immunization, and tobacco	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS composite score related to outpatient care for diabetes and ischemic heart disease	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 27, 2021

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts

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

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

1. I have reviewed and concur with the response for the draft report of the Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts.
2. I have reviewed the Healthcare System Director's action plan and projected completion dates. I concur with the plan and have complete confidence that the plan will be effective. VISN 1 will assist the Healthcare System's leadership in reaching full compliance in a timely manner.
3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Ryan S. Lilly, MPA

Appendix H: Hospital Director Comments

Department of Veterans Affairs Memorandum

Date: July 26, 2021

From: Director, Edith Nourse Rogers Memorial Veterans' Hospital (518/00)

Subj: Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts

To: VA New England Healthcare System (10N1)

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts. I appreciate the Office of Inspector General's oversight and the extensive work done as part of this review. We acknowledge there are improvements to be made and we are committed to timely implementation of Office of Inspector General recommendations.
2. I have reviewed the action plans and projected completion dates. I concur with the plan and have complete confidence that the plans will be effective.
3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Dr. Joan Clifford, DNP

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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