DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Lexington VA Health Care System in Kentucky

CHIP REPORT | REPORT #21-03308-24 | December 13, 2022

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Figure 1. *Lexington VA Health Care System in Kentucky.*
Source: https://www.va.gov/lexington-health-care/.

Abbreviations

ADPCS	Associate Director of Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CI	confidence interval
CLC	community living center
CSRE	Comprehensive Suicide Risk Evaluation
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Lexington VA Health Care System, which includes the Franklin R. Sousley and Troy Bowling campuses, and multiple outpatient clinics in Kentucky. 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. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

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

The OIG conducted an unannounced inspection of the Lexington VA Health Care System from November 15 through November 19, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued 10 recommendations to the Director, Chief of Staff, Associate Director of Patient Care Services, and Associate Director in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; Environment of Care; and Mental Health. These results are detailed throughout the report and summarized in appendix A on page 29.

Conclusion

The OIG issued 10 recommendations for improvement to the Director, Chief of Staff, Associate Director of Patient Care Services, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that may eventually interfere with the delivery of quality healthcare.

VA Comments

The Veterans Integrated Service Network Director and interim Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 32–33, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 7 and 9 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

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

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

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

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

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.
[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014), 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] CHIP site visits address these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The Lexington VA Health Care System includes the Franklin R. Sousley and Troy Bowling campuses and associated outpatient clinics in Kentucky. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from February 11, 2017, through November 19, 2021, the last day of the unannounced multiday evaluation.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

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

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

[5] The OIG's last comprehensive healthcare inspection of the Lexington VA Health Care System occurred in February 2017. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in June 2019.
[6] Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Leadership and Organizational Risks

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

To assess this healthcare system's leadership and risks, the OIG considered several indicators:

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

Executive Leadership Position Stability and Engagement

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 2 illustrates this healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the Director, Associate Director, Associate Director of Patient Care Services (ADPCS), and Chief of Staff. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had been in place for less than five months. To help assess the executive leaders' engagement, the OIG interviewed the acting

[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs,* Institute for Healthcare Improvement White Paper, 2013.
[8] Swensen, *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs.*
[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

Director, Deputy Chief of Staff, acting ADPCS, and acting Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.[10]

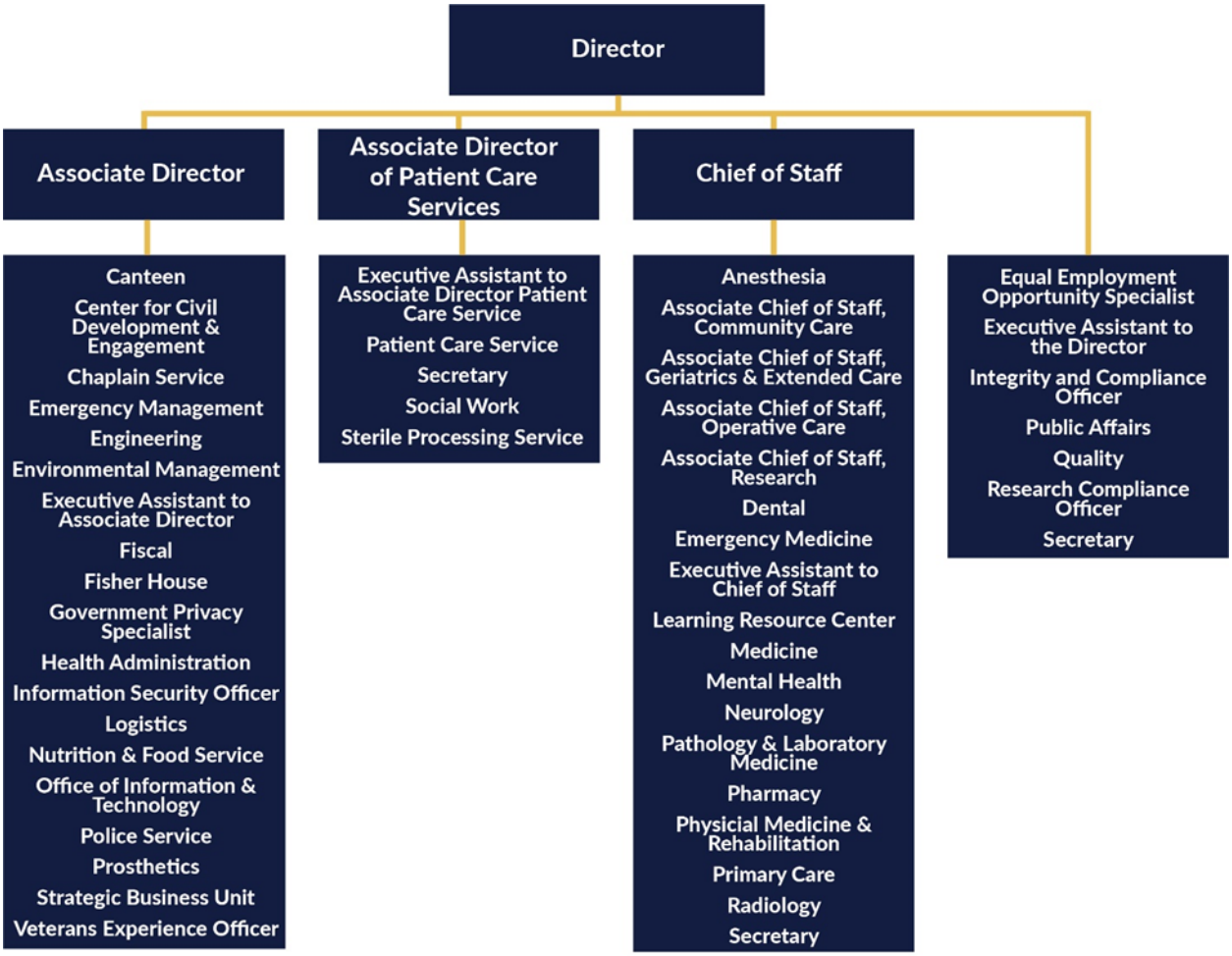

Figure 2. *Healthcare system organizational chart.*

Source: Lexington VA Health Care System (received June 30, 2022).

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $487,615,819 had increased by about 4 percent compared to the previous year's budget of $470,354,528.[11] The acting Associate Director reported using these funds in part to pay for a new community living center (CLC), dental unit, and optometry project, as well as a new inpatient

[10] At the time of the OIG inspection, the Director and ADPCS had been detailed to the VISN; therefore, the Associate Director was the acting Director, and the Chief Nurse, Acute Patient Care was the acting ADPCS. The Chief Financial Officer served as the acting Associate Director. The Chief of Staff was unavailable for interview, so the OIG interviewed the Deputy Chief of Staff.

[11] VHA Support Service Center (VSSC).

mental health unit at the Troy Bowling campus. The acting Director also described buying oxygen concentrators, filters, and air circulators.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] The instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[13] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

To assess employee attitudes toward healthcare system leaders and the workplace, the OIG reviewed results from the Veterans Health Administration's (VHA) All Employee Survey from FYs 2019 to FY 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[14] The OIG found that the healthcare system and leaders' averages were generally equal to or better than VHA averages. The scores for the Director were higher than VHA and system averages in each of the years reviewed. The acting Director attributed these scores to modifying the culture to truly embrace servant leadership. The scores for the ADPCS were equal to or slightly lower than VHA averages and improved from FY 2020 to 2021. The acting ADPCS associated the improvement with hiring nurses who demonstrated servant leader qualities.

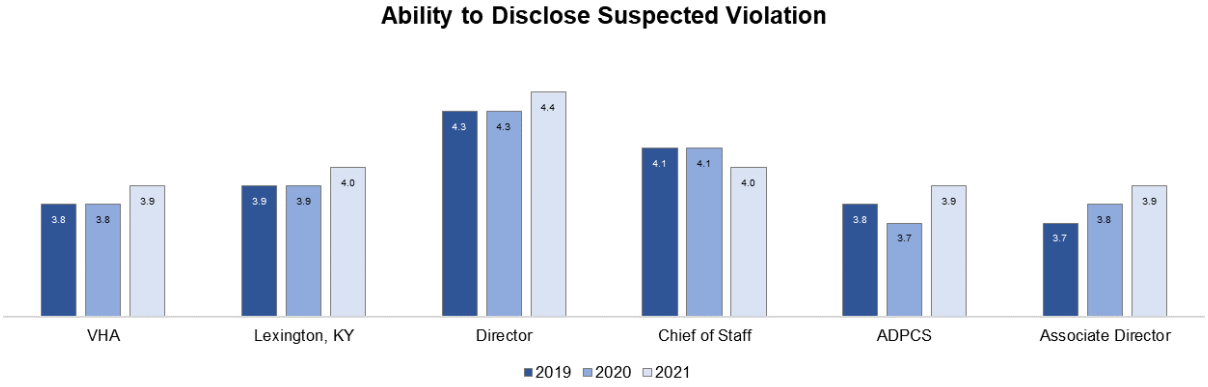

Figure 3. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

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

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

[12] "AES Survey History, Understanding Workplace Experiences in VA," VSSC website.
[13] "AES Survey History, Understanding Workplace Experiences in VA," VSSC website.
[14] 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.

Patient Experience

VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their healthcare and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patient program.[15]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[16] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from October 2017 (FY 2018), through June 2021. Figures 4–6 provide survey results for VHA and the healthcare system over time.[17]

[15] "Patient Experiences Survey Results," VSSC website.
[16] "Patient Experiences Survey Results," VSSC website.
[17] Scores are based on responses by patients who received care at this healthcare system.

The healthcare system's inpatient satisfaction survey results reflected higher care ratings than the VHA averages, except in FY 2021. The Deputy Chief of Staff and acting Director stated that during FY 2021, visitor restrictions due to the COVID-19 pandemic impeded communication between veterans and their families. The Deputy Chief of Staff indicated that leaders realized the importance of family contact with veterans and reexamined the visitor policy. The acting ADPCS said that leaders implemented daily visits to patient care areas by the charge nurse, nurse manager, and chief nurse. During the visits, these staff asked patients a few simple questions directly related to their experience, such as if they needed assistance and liked the food.

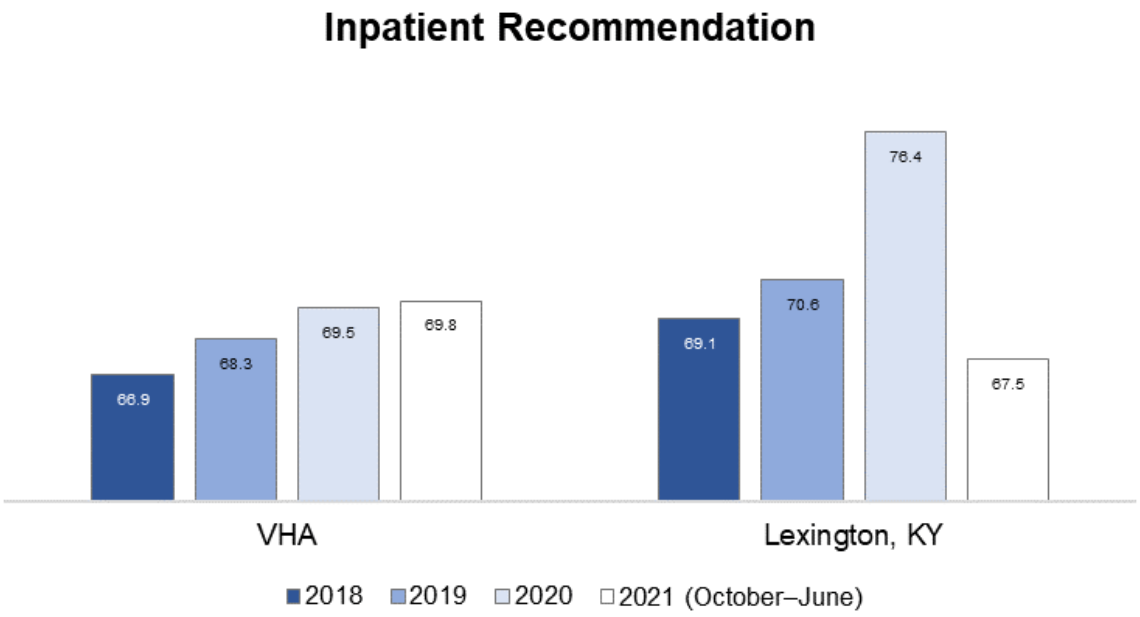

Figure 4. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 21, 2021).

Note: The score is the percent of "Definitely Yes" responses.

The healthcare system's primary care satisfaction survey results consistently reflected higher care ratings than the VHA averages. The acting ADPCS attributed these results to ensuring patient aligned care teams and other primary and ambulatory care staff delivered quality care, following up to be sure that care in the community was timely, and allowing time for primary care staff to develop relationships with the veterans.

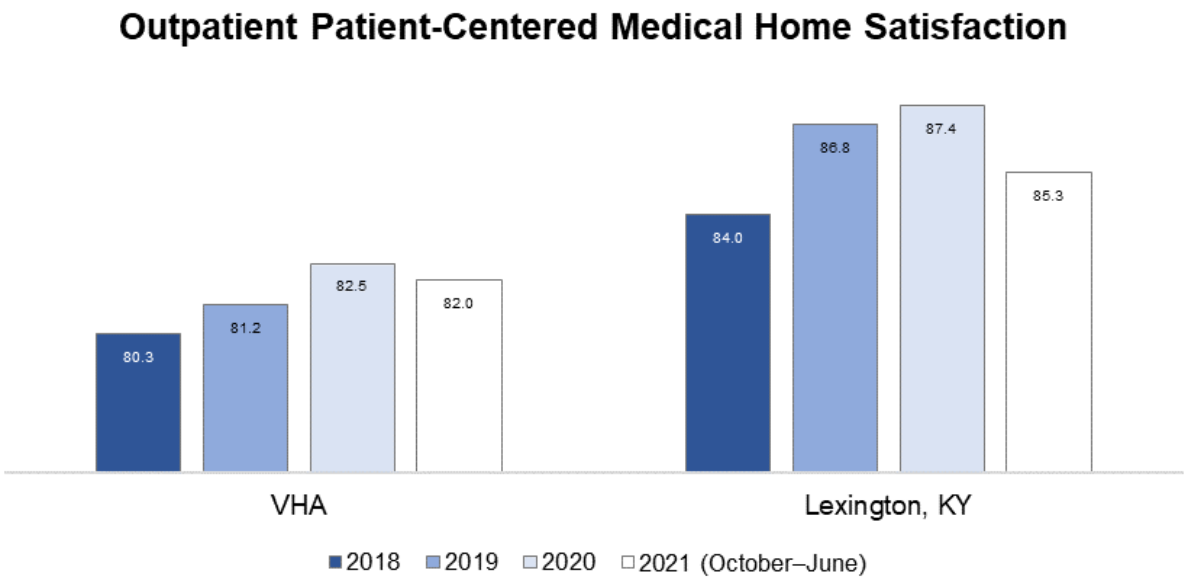

Figure 5. *A Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the healthcare you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 21, 2021).

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

For outpatient specialty care, the healthcare system's patient satisfaction survey scores were higher than the VHA averages. In individual interviews, executive leaders were able to speak about actions taken during the previous 12 months to improve outpatient specialty care satisfaction. The acting ADPCS attributed these results to the variety of specialty care services offered, which included podiatry, surgical care, and physical therapy. The acting ADPCS also indicated that leaders planned to continue their activities to maintain these results.

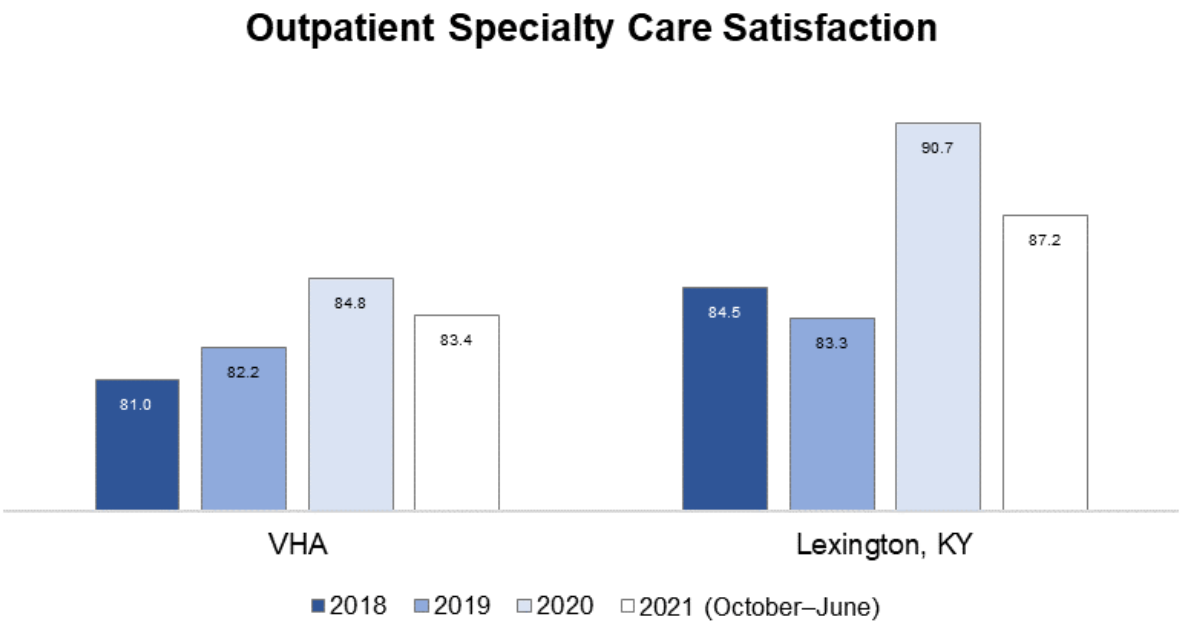

Figure 6. *A Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the healthcare you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 21, 2021).

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

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

Leaders must ensure that patients receive high-quality healthcare that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[18] VHA defines a sentinel event as an incident or condition that "results in death, permanent harm, or severe temporary harm and [where] intervention [is] required to sustain life."[19] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with

[18] Frankel, *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, https://www.va.gov/QUALITYANDPATIENTSAFETY/.
[19] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[20] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

Table 1 lists the reported patient safety events from February 11, 2017 (the prior OIG Clinical Assessment Program site visit), to November 15, 2021.

Table 1. Summary of Selected Organizational Risk Factors (February 11, 2017, to November 15, 2021)

Factor	Number of Occurrences
Sentinel Events	3
Institutional Disclosures	10
Large-Scale Disclosures	0

Source: Lexington VA Health Care System's Risk Manager, Patient Safety Manager (received November 15, 2021).

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's (TJC) standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[22] If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[23] The acting Director reported being aware of patient safety issues and was generally knowledgeable regarding processes for institutional disclosures and actions taken in response to sentinel events.

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG site visit, the executive leadership team had worked together for less than five months. Employee satisfaction survey results regarding employees' perceived ability to

[20] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.
[21] VHA Directive 1004.08.
[22] TJC, *Standards Manual*, E-dition, July 1, 2022.
[23] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events, 2nd ed.,* Institute for Healthcare Improvement White Paper, 2011.

disclose a suspected violation without fear of reprisal for the Director were more favorable than VHA averages. Patient experience survey scores revealed opportunities for leaders to improve inpatient satisfaction. The OIG made no recommendations.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[24] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain TJC accreditation.[25] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from TJC).[26]

To determine whether VHA facilities have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system's committee responsible for oversight of healthcare operations and its ability to review data and ensure that key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[27] 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."[28] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[29]

Finally, the OIG assessed the healthcare system's culture of safety.[30] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes and other relevant information.

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[24] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[25] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. This directive was rescinded and replaced by VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.
[26] VHA Directive 1100.16.
[27] A peer review is a "critical review of care, performed by a peer" to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.
[28] VHA Directive 1190.
[29] VHA Directive 1190.
[30] A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organizations health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, accessed October 3, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

Quality, Safety, and Value Findings and Recommendations

The OIG identified a weakness with the peer review process.

VHA requires the peer review committee to complete a final review of peer review cases and recommend "non-punitive, non-disciplinary actions to improve the quality of health care delivered."[31] The OIG reviewed five cases and found that none of the five final Level 3 peer reviews contained evidence that the Peer Review Committee recommended improvement actions, which likely prevented improvements in the providers' patient care practices. The Deputy Chief of Staff stated that while the Peer Review Committee holds robust discussions for each peer review case that may include improvement actions, the need to recommend and document improvement actions was overlooked.

Recommendation 1

1. The Director evaluates and determines any additional reasons for noncompliance and ensures the Peer Review Committee recommends improvement actions for all Level 3 peer reviews.

Healthcare system concurred.

Target date for completion: 11/30/2022

Healthcare system response: On 2/16/2022, the Risk Manager educated the Peer Review Committee (PRC) members on the requirement for recommending improvement actions. On 2/16/2022, the PRC coordinator updated the PRC minutes to incorporate committee recommendations for improvement on Level 2 and 3 cases. The Chief, Quality, Performance, and Patient Safety will audit PRC minutes every month until 90 percent compliance is sustained for 6 consecutive months. Audit data will be reported in the PRC. The numerator will be the number of Level 2 and 3 cases with committee recommendations for improvement in PRC minutes, and the denominator will be the number of all Level 2 and 3 cases in the PRC minutes.

[31] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently."[32] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[33]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[34] LIPs are granted clinical privileges for no more than two years and must be reprivileged prior to their expiration.[35]

VHA defines the Focused Professional Practice Evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[36] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[37] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation (OPPE) to ensure the continuous delivery of quality care.[38]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[39] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the Chief of Staff. VHA also requires facilities to have credentialing

[32] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (The credentialing portion of this handbook was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)
[33] VHA Handbook 1100.19.
[34] VHA Handbook 1100.19.
[35] VHA Handbook 1100.19.
[36] VHA Handbook 1100.19.
[37] VHA Handbook 1100.19.
[38] VHA Handbook 1100.19.
[39] VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.

and privileging managers and specialists with job duties that align under standard position descriptions.[40]

The OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

- Two solo/few practitioners who underwent clinical privileging in the previous 12 months[41]
- Five LIPs who had FPPEs completed in the previous 12 months
- Twenty LIPs who were reprivileged in the previous 12 months

Medical Staff Privileging Findings and Recommendations

The OIG found weaknesses with FPPE and OPPE processes.

VHA requires FPPE criteria to "be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process and approved by the Director."[42] The OIG reviewed five practitioner profiles and found that all five lacked evidence that the LIPs were aware of and had accepted the evaluation criteria before service chiefs initiated the FPPE process. When practitioners are not informed of the evaluation criteria, they may not understand FPPE expectations. The Deputy Chief of Staff reported misunderstanding the standards and believing that undocumented FPPE criteria discussions during practitioners' new employee orientation met the requirement.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs define Focused Professional Practice Evaluation criteria in advance.

[40] Assistant Under Secretary for Health for Operations memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.
[41] VHA refers to a solo practitioner as being one provider in the facility who is privileged in a particular specialty. Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners," August 29, 2016. (This memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on December 18, 2020. The December 18, 2020, memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on May 18, 2021). The OIG considers a few practitioners as being two providers in the facility who are privileged in a particular specialty.
[42] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: 9/30/2022

Healthcare system response: Modernization of FPPE/OPPE forms to the nationally mandated criteria has been completed which included an additional signature line to acknowledge notification to licensed independent practitioners (LIPs) in advance. The forms were approved through the Medical Executive Committee and implemented on 12/31/2021. All forms are provided by the Credentialing & Privileging Manager in 6 month increments and were reported to the Healthcare Delivery Council (HDC) on 5/31/2022. The Credentialing & Privileging Manager will review 6 months of forms provided until 90 percent compliance is sustained. Audit data will be reported by the Credentialing & Privileging Manager in the HDC. The numerator will be the number of FPPE forms that show evidence that the criteria for the FPPE process was defined to LIPs in advance, and the denominator will be the number of FPPE forms reviewed.

VHA requires the chief of staff to ensure that LIPs are evaluated on an ongoing basis by providers with similar training and privileges.[43] The OIG found that 5 of 22 OPPEs (including for one solo practitioner) reviewed contained results that were not based on an evaluation by a provider with similar training and privileges. This could result in LIPs providing care without a thorough evaluation of their practice, which could adversely affect quality of care and jeopardize patient safety. The Deputy Chief of Staff, the former acting Chief of Anesthesiology, and the Chief of Medicine stated they believed that review by an LIP in the same service, regardless of similar privileges and training, met the requirement.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers with similar training and privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.

[43] Acting DUSHOM memo, "Requirements for Peer Review of Solo Practitioners."

Healthcare system concurred.

Target date for completion: 9/30/2022

Healthcare system response: A Standard Work Tool (SWT) was created by the Credentialing & Privileging Manager on 2/25/2022 to include OPPE results that are based on evaluation by a similarly privileged and trained provider. This SWT was electronically sent on 3/3/2022 to service chiefs with a read receipt and was added to the Medical Staff Office (MSO) SharePoint on 3/3/2022. All read receipts were confirmed. All OPPE forms are provided by the Credentialing & Privileging Manager in 6 month increments and were reported to the Healthcare Delivery Council (HDC) on 5/31/2022. The Credentialing & Privileging Manager will review 6 months of forms provided until 90 percent compliance is sustained. Audit data will be reported by the Credentialing & Privileging Manager in the HDC. The numerator will be the number of OPPE forms showing evidence that results were based on evaluation by a similarly privileged and trained provider, and the denominator will be the number of OPPE forms reviewed.

VHA requires that service chiefs' determinations to continue current privileges are based, in part, on OPPE activities such as direct observation, clinical pertinence reviews, and clinical discussions.[44] The OIG found that for 9 of 22 LIPs reprivileged within the previous 12 months, service chiefs could not demonstrate that determination to continue privileges was based on OPPE activities. When service chiefs' evaluations lack adequate data to support recommendations to continue privileges, it may affect the delivery of quality patient care. The Executive Assistant to the Chief of Staff (formerly the Administrative Officer for Surgery Service) stated that evidence of timely review of surgery service OPPE data was not captured due to insufficient communication of the process and responsibilities to the new Administrative Officer. The Associate Group Practice Manager, Primary Care was unable to provide a reason for the inability to locate primary care OPPEs or evidence of OPPE activities.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that service chiefs' determinations to continue current privileges are based on Ongoing Professional Practice Evaluation activities.

[44] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: 9/30/2022

Healthcare system response: A new electronic process was added to the Medical Staff Office (MSO) SharePoint on 2/10/2022. A folder for each service was set up and all OPPE forms were added. Individual folders were created for each service and provider. This new process enables MSO office staff to track, audit, and present at the Medical Executive Committee (MEC) during the credentialing and re-credentialing periods. All OPPE forms are provided by the Credentialing & Privileging Manager in 6 month increments and were reported to the Healthcare Delivery Council (HDC) on 5/31/2022. The Credentialing & Privileging Manager will review 6 months of forms provided until 90 percent compliance is sustained. Audit data will be reported by the Credentialing & Privileging Manager in the HDC. The numerator will be the number of OPPE forms with evidence that the service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities, and the denominator will be the number of OPPE forms reviewed.

VHA also requires an executive committee of the medical staff to recommend continuation of privileges based on OPPE results.[45] The OIG found that for 8 of 22 OPPEs, the Medical Executive Committee recommended continuation of privileges but could not provide evidence that decisions were based in part on OPPE results. Consequently, providers delivered care based on insufficient data to evaluate their practice. The Deputy Chief of Staff reported believing that service chiefs' verbal reports to the Medical Executive Committee recommending continuation of privileges were sufficient for the committee to make their determinations.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Medical Executive Committee's decision to recommend continuation of privileges is based on Ongoing Professional Practice Evaluation results.

[45] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: 9/30/2022

Healthcare system response: On 1/5/2022, the Credentialing & Privileging Manager updated the Medical Executive Committee (MEC) meeting minutes to reflect evidence that the MEC reviewed and considered OPPE results in their re-privileging determinations. Medical Staff Office (MSO) SharePoint and OPPE documents are presented by the Credentialing & Privileging Manager and reviewed during each MEC meeting. The Credentialing & Privileging Manager will review MEC minutes every month until 90 percent compliance is sustained for 6 consecutive months. Audit data will be reported by the Credentialing & Privileging Manager to the Healthcare Delivery Council. The numerator will be the number of MEC minutes that reflect evidence that the MEC reviewed and considered OPPE results in their re-privileging determinations, and the denominator will be the number of MEC minutes reviewed.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[46] The physical environment of a healthcare organization must not only be functional but should also promote healing.

The purpose of this inspection was to determine whether VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG assessed compliance in selected areas that are often associated with higher risks of harm to patients; these areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and CLCs, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[47]

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid-related. This was an increase from 56,064 in the previous 12 months.[48] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times to emergencies and contribute to a safe healthcare environment.[49]

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

- Troy Bowling division
  - Emergency Department

[46] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (This directive was rescinded and replaced with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.)
[47] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008.
[48] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.
[49] Opioids are medications that are "effective at reducing pain" but "when taken in excess, can lead to respiratory arrest." Naloxone is a highly effective treatment for reversing an opioid overdose. "Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit," VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, "Automated External Defibrillators (AEDs)," accessed December 16, 2021, https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds. "Pharmacy Benefits Management Services," Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

- Intensive care unit (6 South)
- Medical/surgical inpatient unit (Telemetry 5 North and 5 South)
- Mental health inpatient unit (4 South)

- Franklin R. Sousley division
  - CLC 1 (27-1)
  - CLC 2 (27-2)
  - Primary care clinic (16-1)

Environment of Care Findings and Recommendations

The OIG identified vulnerabilities with Rapid Naloxone Initiative implementation, supply storage, environmental cleanliness, infection prevention, and inpatient mental health general safety.

VHA states that facilities that implement an intranasal naloxone program must create a local intranasal naloxone policy that specifically addresses accountable individuals, as well as other facility-specific information or aspects that may affect implementation.[50] The OIG found a local naloxone policy that expired in June 2020 and had not been updated. The lack of a written policy could hinder compliance with VHA requirements and delay the administration of naloxone in the event of an overdose. The Pharmacy Program Manager-Investigational Drugs and Research stated that the system's naloxone policy, created in 2018, was initially an interprofessional collaboration between pharmacy, mental health, nursing, and other services and attributed the noncompliance to miscommunication regarding policy ownership. The Pharmacy Program Manager-Investigational Drugs and Research added that prioritizing COVID-19 pandemic response efforts hindered policy reviews and updates.

Recommendation 6

6. The Director evaluates and determines any additional reasons for noncompliance and ensures staff have a current local intranasal naloxone policy.

[50] "Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit," VHA website.

Healthcare system concurred.

Target date for completion: 1/31/2023

Healthcare system response: The Chief of Pharmacy or designee will review the Intranasal Naloxone Standard Operating Procedure 119-01 and Automated External Defibrillator Cabinet Naloxone Program: Implementation Toolkit requirements to create a local intranasal naloxone policy. This policy will be discussed in the Pharmacy & Therapeutics Committee, then processed to the Director for final approval.

VHA requires the ADPCS to ensure "[e]xpiration dates on commercial products…[are] adhered to as they reflect product usability or stability rather than sterility of the contents."[51] In two of seven patient care areas inspected, the OIG found outdated tongue depressors and saline solution for irrigation.[52] The use of expired supplies may pose risks to those seeking healthcare services. The CLC Assistant Nurse Manager was unaware of expired items in the CLC supply room and cited miscommunication between logistics and nursing staff regarding responsibilities for checking expiration dates. Additionally, the Assistant Chief of Logistics cited infrequent use as the likely reason product expirations were overlooked.

Recommendation 7

7. The Associate Director of Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain managers adhere to commercial product expiration dates in the community living center.[53]

[51] VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
[52] Deficient areas were CLC 1 (27-1) and CLC 2 (27-2).
[53] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: On 11/22/2021, all stock in closets was inspected by the Inventory Management Supervisor for expiration dates and all expired supplies were removed and processed. By 12/17/2021, the VISN 9 Supervisor, Supply Systems Analyst completed re-training on First In/First Out and Sterile Supply Management for all Logistics service staff. On 12/13/2021, all supply room inspection sheets were updated to a modern template. By 12/17/2021, Logistic Services staff were educated on the updated inspection sheets by the VISN 9 Supervisor, Supply Systems Analyst through daily huddles. The Inventory Management Supervisor will perform weekly checks of all supply closets until 90 percent compliance is sustained for 6 consecutive months. The numerator will be the number of supply closets inspected at the Community Living Center (CLC) with no expired commercial or medical supplies during weekly checks, and the denominator will be the number of supply closets located at the CLC.

We performed weekly checks of all supply closets and achieved greater than 90 percent compliance for 6 consecutive months. We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

TJC requires hospitals to keep furnishings and equipment safe and in good repair.[54] The OIG found damaged furniture in three of the seven areas inspected at the Franklin R. Sousley and Troy Bowling divisions, including the CLCs.[55] This may have prevented effective cleaning and disinfection of the furniture. The Assistant Chief of Environmental Management Services reported ordering new replacement furniture but cited national delays that compromised the delivery and replacement. Additionally, the Assistant Chief of Environmental Management Services reported that due to COVID-19 safety measures, visitors and non-CLC staff had restricted access to the CLC, which limited the frequency of environment of care inspections.

Recommendation 8

8. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures managers keep furnishings safe and in good repair.

[54] TJC, *Standards Manual*, EC.02.06.01, EP 26.
[55] Deficient areas were the Franklin R. Sousley CLC 1 (27-1) and CLC 2 (27-2) and the Troy Bowling intensive care unit (6 South).

Healthcare system concurred.

Target date for completion: 2/28/2023

Healthcare system response: On 7/28/2022, the monthly Service Safety Team Inspection Program Checklist was updated to include "furnishings [are] safe and in good repair." This checklist is completed in all clinical inpatient/outpatient areas and turned in to Safety Engineering on the 17th of each month. Compliance is reported in the Environment of Care (EOC) Committee. On 7/28/2022, the updated checklist was sent to the Service Safety Sub Committee of the EOC Committee email group that includes all leadership of services and points of contact of the services. In addition to the monthly checklist, furnishings will be inspected during EOC rounds twice a year. Deficiencies identified during EOC rounds are documented in [the] Performance Logic application and tracked to completion, trended, and data [are] reported monthly to the EOC Committee.

VHA states the facility chief of staff and nurse executive (ADPCS) are responsible for ensuring staff "understand the hazards" of environmental risks for suicide and suicide attempts in acute inpatient mental health units and "develop appropriate abatement plans."[56] At the Troy Bowling division, the OIG observed the following anchor points in the inpatient mental health unit: an unsecured sink trap cover in a patient restroom, locker doors with open ventilation louvers, and locker hinges without a sloped surface.[57] These deficiencies could result in harm to patients. The Patient Safety Manager was aware of the requirement and believed the locker louvers, hinges, and a newly installed sink trap cover met the intent of the standards. After the OIG raised concerns, the Chief of Quality, Performance, and Patient Safety reported that staff were taking immediate action to mitigate the risks by removing the locker doors and securing a rubber covering over sink trap covers until new sinks could be purchased.

Recommendation 9

9. The Chief of Staff and Associate Director of Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that staff develop abatement plans to minimize risks for suicide and suicide attempts in acute inpatient mental health units.[58]

[56] VHA Directive 1167, *Mental Health Environmental of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.
[57] "A louver is a ventilation product that allows air to pass through it…[a] number of fixed or operable blades mounted in a frame can provide this functionality." "How Louvers Work," Architectural Louvers, accessed July 17, 2022, https://www.archlouvers.com/How_Louvers_Work.htm.
[58] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: On 11/30/2021, completions of hinges being removed from lockers and vents covered. On 1/4/2022, all installation on new sinks and vent that are closed trap without opening was completed. Ligature risks will be monitored, and staff educated on ligature risks during Safety Rounds biweekly and during Mental Health Environment of Care Checklist (MHEOCC) every 6 months by the 4 South Program Manager. Safety Rounds and MHEOCC data are corrected and tracked to completion. MHEOCC data documented in the Patient Safety Assessment Tool (PSAT).

We completed actions for this recommendation and would like to request closure prior to publication based on supporting evidence provided to the OIG.

Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives

Suicide prevention remains a top priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides."[59] Additionally, "among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019."[60]

VHA implemented various evidence-based approaches to reduce veteran suicides, including a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale and subsequent completion of the Comprehensive Suicide Risk Evaluation (CSRE) when the screening is positive.[61] The OIG examined electronic health records to determine whether staff completed the CSRE for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

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 emergency departments or urgent care centers and receive "structured post-discharge follow-up to facilitate engagement in outpatient mental health care."[62] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patient discharge from emergency departments or urgent care centers and follow-up within seven days of discharge.

To determine whether VHA facilities complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 45 randomly selected patients who were seen in the emergency department or urgent care center from December 31, 2020, through August 1, 2021.

Mental Health Findings and Recommendations

The OIG found that providers did not complete all elements of the CSRE when assessing patients for suicide risk.

[59] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.
[60] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report.*
[61] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020.
[62] Deputy Under Secretary for Health for Operations and Management memo, "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.

VHA requires facility staff to "complete 100% of required universal and setting-specific screenings and CSREs."[63] Additionally, all patients who screen positive for suicide risk in the emergency department or urgent care center must have a CSRE that includes assessment of whether the patient's most recent suicide attempt was the most lethal.[64] The OIG estimated that providers did not determine if the most recent suicide attempt was the most lethal in 58 (95% CI: 29 to 87) percent of patients, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[65] Failure to include all required CSRE elements could result in missed opportunities for providers to identify patients who are at imminent risk for suicide. The Suicide Prevention Coordinator stated that providers were unaware of the requirement due to a lack of training specific to the VHA policy.

Recommendation 10

10. The Director evaluates and determines any additional reasons for noncompliance and ensures providers complete 100 percent of required universal and setting-specific screenings and Comprehensive Suicide Risk Evaluations.

Healthcare system concurred.

Target date for completion: 10/31/2022

Healthcare system response: On 2/15/2022, additional Comprehensive Suicide Risk Evaluation (CSRE) training was provided to all Mental Health Emergency Department providers during [a] staff training session by the acting Suicide Prevention Coordinator. Training included documentation of provider assessment of whether the suicide ideation was the most severe in the last 30 days and [if] patients who had a suicide attempt since their previous CSRE have a provider assessment of whether the most recent suicide attempt was the most lethal attempt. The acting Suicide Prevention Coordinator will review all records in the Emergency Department every month until 90 percent compliance is sustained for 6 consecutive months. Audit data will be reported by the acting Suicide Prevention Coordinator in the Healthcare Delivery Council. The numerator will be the number of medical records reviewed with all required CSRE elements documented, and the denominator will be the number of medical records reviewed that require a CSRE.

[63] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)."
[64] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)."
[65] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines 10 OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, ADPCS, and Associate Director. 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 that, if left unattended, may potentially interfere with the delivery of quality healthcare.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• The Peer Review Committee recommends improvement actions for all Level 3 peer reviews.
Medical Staff Privileging	• Service chiefs define Focused Professional Practice Evaluation criteria in advance. • Providers with similar training and privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners. • Service chiefs' determinations to continue current privileges are based on Ongoing Professional Practice Evaluation activities. • The Medical Executive Committee's decision to recommend continuation of privileges is based on Ongoing Professional Practice Evaluation results.
Environment of Care	• Staff have a current local intranasal naloxone policy. • Managers adhere to commercial product expiration dates in the community living center. • Managers keep furnishings safe and in good repair. • Staff develop abatement plans to minimize risks for suicide and suicide attempts in acute inpatient mental health units.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Providers complete 100 percent of required universal and setting-specific screenings and Comprehensive Suicide Risk Evaluations.

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1b) affiliated healthcare system reporting to VISN 9.[1]

Table B.1. Profile for Lexington VA Health Care System (596)
(October 1, 2018, through September 30, 2021)

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020	Healthcare System Data FY 2021‡
Total medical care budget	$398,788,015	$470,354,528	$487,615,819
Number of:			
• Unique patients	38,353	36,902	37,410
• Outpatient visits	568,061	559,138	579,282
• Unique employees§	1,948	1,915	1,969
Type and number of operating beds:			
• Community living center	50	50	50
• Domiciliary	30	30	30
• Medicine	58	58	58
• Mental health	14	14	14
• Surgery	20	20	20
Average daily census:			
• Community living center	36	32	24
• Domiciliary	22	12	14
• Medicine	46	40	49
• Mental health	8	6	5
• Neurology	1	1	1

[1] VHA medical facilities are classified according to a complexity model; a designation of "1b" indicates a facility with "medium-high volume, high risk patients, many complex clinical programs, and medium-large sized research and teaching programs." "Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). An affiliated healthcare system is associated with a medical residency program.

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
• Surgery	9	8	7

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

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

*****October 1, 2018, through September 30, 2019.*
†October 1, 2019, through September 30, 2020.*

‡October 1, 2020, through September 30, 2021.*

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 10, 2022

From: Director, VA MidSouth Healthcare Network (10N9)

Subj: Comprehensive Healthcare Inspection of the Lexington VA Health Care System in Kentucky

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

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

1. Thank you for the opportunity to review and respond to the Draft Report Chip-Lexington KY (54CH01). I concur with the findings, recommendations, and submitted action plans.

2. We have been actively working on improvements. We appreciate the perspective from the Office of Inspector General evaluation and will take this opportunity to continue to strengthen and improve our medical center processes.

(Original signed by:)

Gregory Goins, FACHE
Network Director, VISN 9

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: August 5, 2022

From: Interim Director, Lexington VA Health Care System (596/00)

Subj: Comprehensive Healthcare Inspection of Lexington VA Health Care System in Kentucky

To: Director, VA MidSouth Healthcare Network (10N9)

Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of Lexington VA Health Care System.

(Original signed by:)

Becky D. Rhoads, Au.D.
Interim Medical Center Director
Lexington VA Health Care System

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