DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Memphis VA Medical Center in Tennessee

CHIP REPORT | REPORT #21-03310-54 | FEBRUARY 14, 2023

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Figure 1. *Memphis VA Medical Center in Tennessee.*
Source: https://www.va.gov/memphis-health-care/locations/ (*accessed November 3, 2022*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
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 Memphis VA Medical Center and associated outpatient clinics in Arkansas, Mississippi, and Tennessee. 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 OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

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

The OIG conducted an unannounced inspection of the Memphis VA Medical Center from December 6 through December 10, 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 medical center'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 medical center 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 and issued six recommendations to the Medical Center Director and Chief of Staff in the following areas of review: Medical Staff Privileging and Environment of Care. These results are detailed throughout the report and summarized in appendix A on page 28.

Conclusion

The OIG issued six recommendations for improvement to the Medical Center Director and Chief of Staff. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for 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 health care.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 31–32, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 4 and 5 closed. 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 Memphis VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so they can make informed decisions to improve care.[1]

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

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

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on 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 F. Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The Memphis VA Medical Center also provides care through associated outpatient clinics in Arkansas, Mississippi, and Tennessee. General information about the medical center can be found in appendix B.

The inspection team examined operations from January 29, 2018, through December 10, 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 available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

[5] The OIG's last comprehensive healthcare inspection of the Memphis VA Medical Center occurred in January 2018. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in January 2019.

[6] Inspector General Act of 1978, as amended, Pub. L. No. 117-286 § 3(b) (to be codified at 5 U.S.C. § 401, *et seq*.).

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 medical center'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 medical center 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 medical center's reported organizational structure. The medical center had a leadership team consisting of the Medical Center Director, Associate Medical Center Director, Assistant Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services (ADPCS). The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At time of the OIG visit, the Medical Center Director, Chief of Staff, and ADPCS were interim or acting. These leaders had worked together with the Associate Medical Center Director for approximately four weeks.[10] The permanent Chief of Staff covered for the Medical Center

[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.

[10] While the Chief of Staff was new to the interim medical center director role, the individual was not new to the executive leadership team.

Director on an interim basis, and the Deputy Chief of Staff served as Chief of Staff, also on an interim basis. The new permanent Assistant Medical Center Director started New Employee Orientation the week of the site visit. To help assess the executive leaders' engagement, the OIG interviewed the Interim Medical Center Director, Interim Chief of Staff, Acting ADPCS, Associate Medical Center Director, and Acting Assistant Medical Center Director regarding their involvement and support of actions to improve or sustain performance.

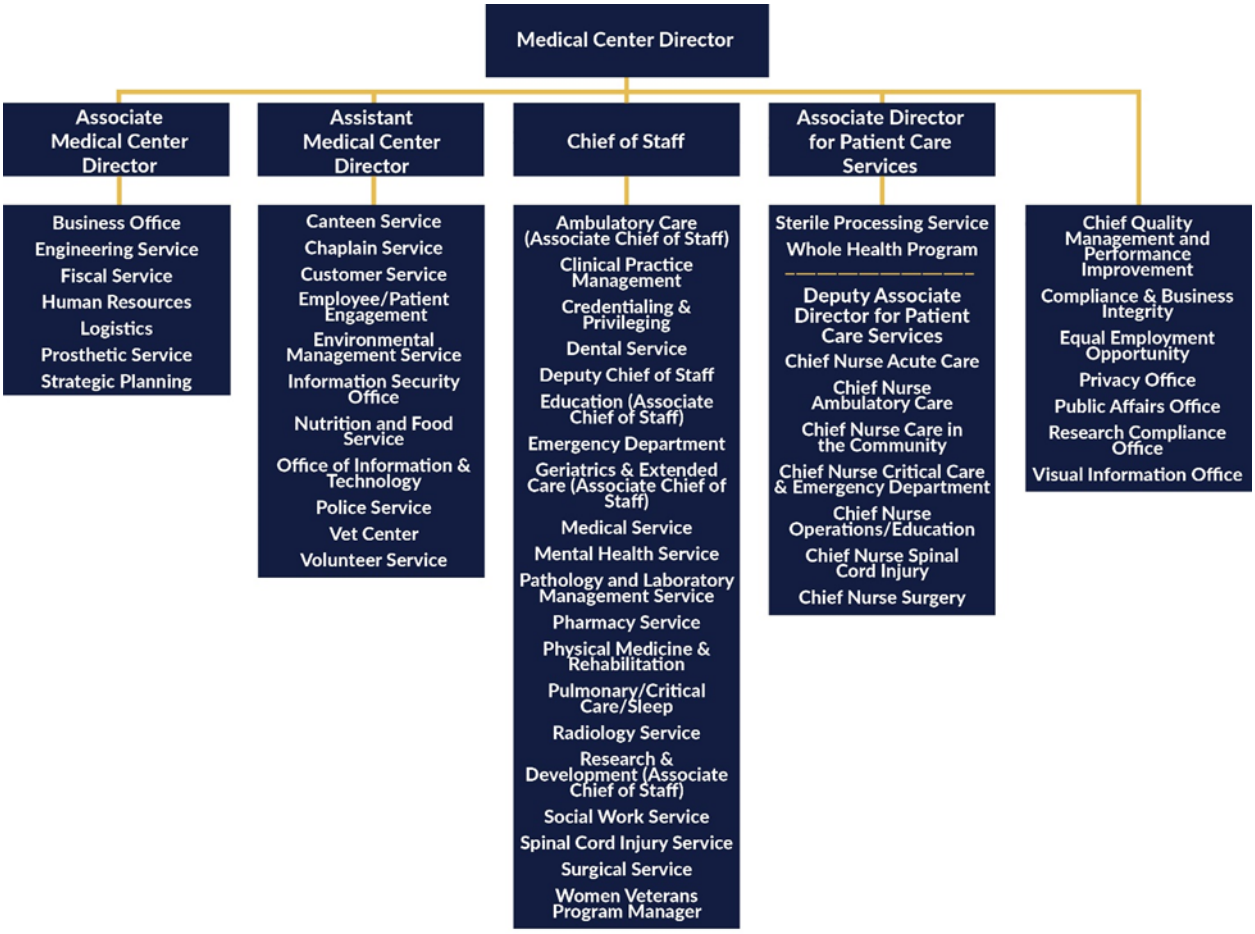

Figure 2. *Medical center organizational chart.*
Source: Memphis VA Medical Center (received December 7, 2021).

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2021 annual medical care budget of $728,403,466 had increased by approximately 11 percent compared to the previous year's budget of $655,233,350.[11] According to the Interim Medical Center Director, leaders used the funding to purchase equipment such as computed tomography scanners, create more isolation rooms, and

[11] VHA Support Service Center (VSSC).

rent additional hospital beds to support patient care during the COVID-19 pandemic.[12] The Interim Medical Center Director also reported that leaders made salary adjustments after conducting a market pay evaluation. The Associate Medical Center Director described undertaking infrastructure repairs and upgrades, which included building a new ambulatory surgery intake and isolation space and completing renovations to the operating room to create cardiothoracic surgery space, the laboratory, and the pool in the spinal cord injury unit. The Associate Medical Center Director reported that additional funding was also spent on pandemic-related expenses for ventilators and outdoor equipment such as generators, air conditioners, heaters, and two-way radio communicators.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] The instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[14] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders and the workplace, the OIG reviewed results from VHA's All Employee Survey from FYs 2019 to 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[15] In FY 2019, the medical center and leaders' averages were similar to or higher than the VHA averages. In FYs 2020 and 2021, the scores for the Medical Center Director, Chief of Staff, and Assistant Medical Center Director were similar to or higher than VHA averages, but those for the ADPCS and Associate Medical Center Director were lower. The Acting ADPCS attributed the lower scores to leadership changes, workload increases, and staffing shortages. The Associate Medical Center Director described organizational realignments to the reporting structure as a factor affecting the scores.

[12] A computed tomography scan is a three-dimensional cross-sectional image of body structures used for diagnostic purposes. *Merriam-Webster.com Dictionary*, "CT scan," accessed June 13, 2022, https://www.merriam-webster.com/dictionary/CT%20scan.

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

[14] "AES Survey History, Understanding Workplace Experiences in VA."

[15] 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. Only the Chief of Staff (serving as Interim Medical Center Director at the time of the site visit) was in the role during the All Employee Survey review period (FY 2019–2021).

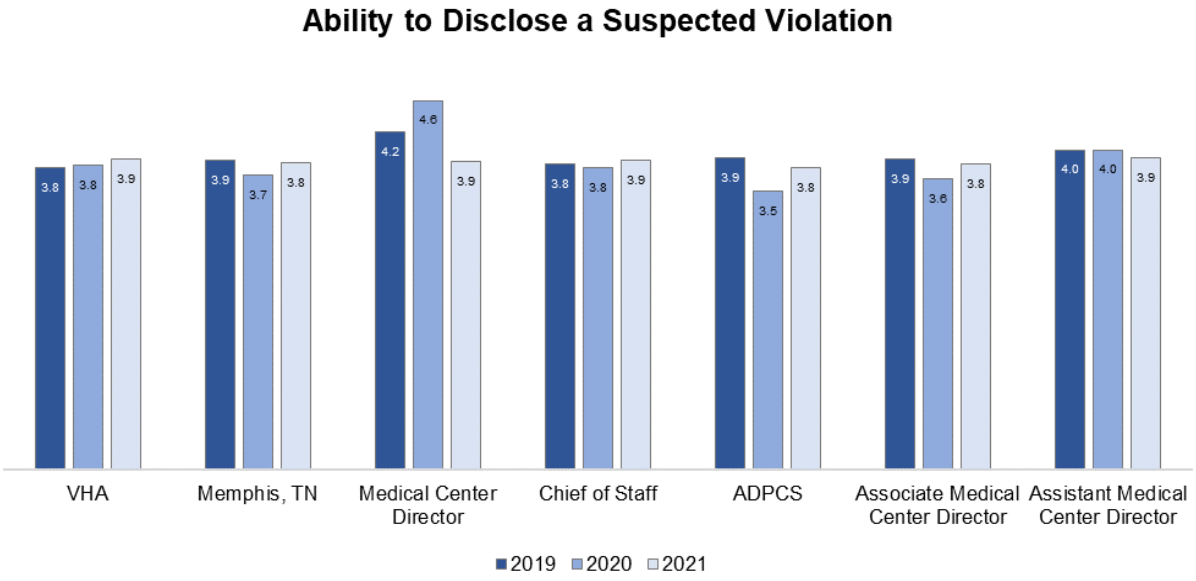

Figure 3. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed November 2, 2021).

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

Patient Experience

VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.[16]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[17] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from October 1, 2017 (FY 2018), through June 2021. Figures 4–6 provide survey scores for VHA and the medical center over time.[18]

The medical center's inpatient satisfaction survey results consistently reflected lower scores than the VHA averages. The Interim Medical Center Director explained that lower inpatient satisfaction scores were related to aging infrastructure and negative community perceptions. The Interim Medical Center Director also stated that the lack of a community living center increased the inpatient length of stay, which was especially challenging during the pandemic because beds

[16] "Patient Experiences Survey Results," VSSC website.

[17] "Patient Experiences Survey Results," VSSC website.

[18] Scores are based on responses by patients who received care at this medical center.

were unavailable at community facilities.[19] The Interim Medical Center Director discussed actions taken to improve patient satisfaction scores such as resuming inpatient interdisciplinary team huddles and partnering with community nursing homes for placements. The Associate Medical Center Director and Interim Chief of Staff described several renovation projects in development, including aesthetic upgrades such as painting and updating furniture.

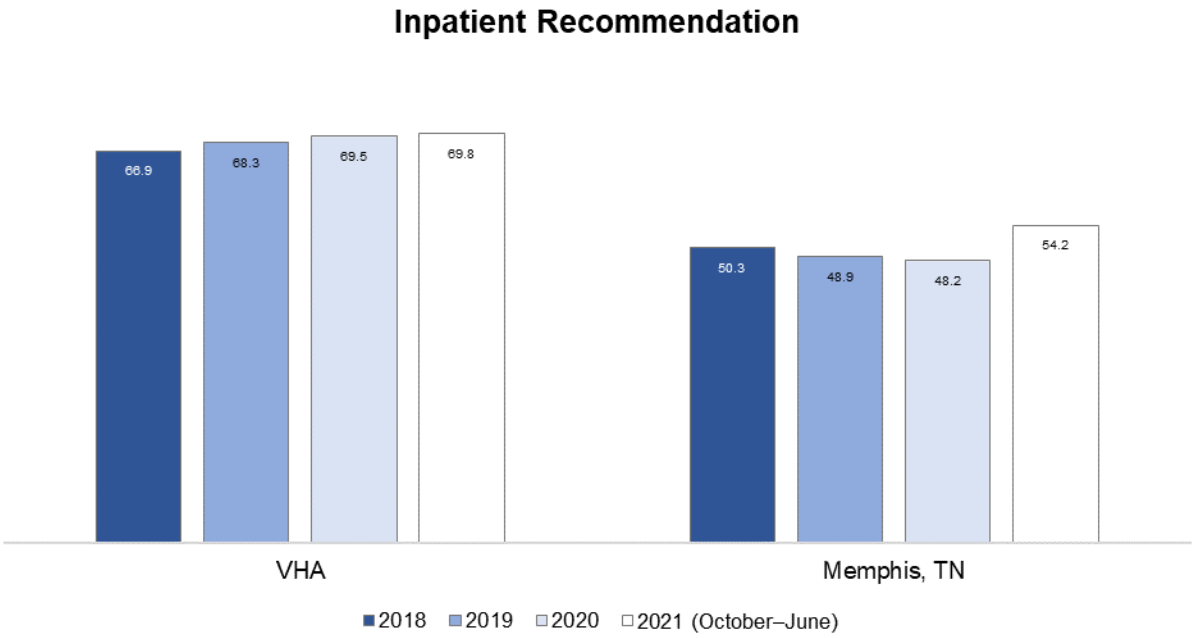

Figure 4. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 20, 2021).

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

The medical center's outpatient satisfaction survey results also consistently reflected lower scores than the VHA averages. The Interim Medical Center Director stated the community's poverty rate and rurality, in addition to negative perceptions of the medical center, were driving factors for lower outpatient satisfaction scores. Executive leaders discussed a focused effort to improve satisfaction by reviewing community-based outpatient clinic utilization. The Interim Medical Center Director reported that many of these clinic spaces were contracted and not staffed by VA providers or available in all areas of need. Leaders reported conducting a market assessment to evaluate areas to expand care.

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

The Interim Chief of Staff explained the medical center was also a teaching hospital, which may have caused dissatisfaction when patients occasionally had to see multiple providers. The Interim Chief further stated that many specialty care providers also cared for patients at the local university and medical center, so they were not available on a full-time basis. Additionally, the Acting ADPCS described licensed practical nursing shortages in the outpatient clinics as a factor contributing to low scores and reported that recent salary surveys supported the need for pay increases to keep the medical center competitive with the community.

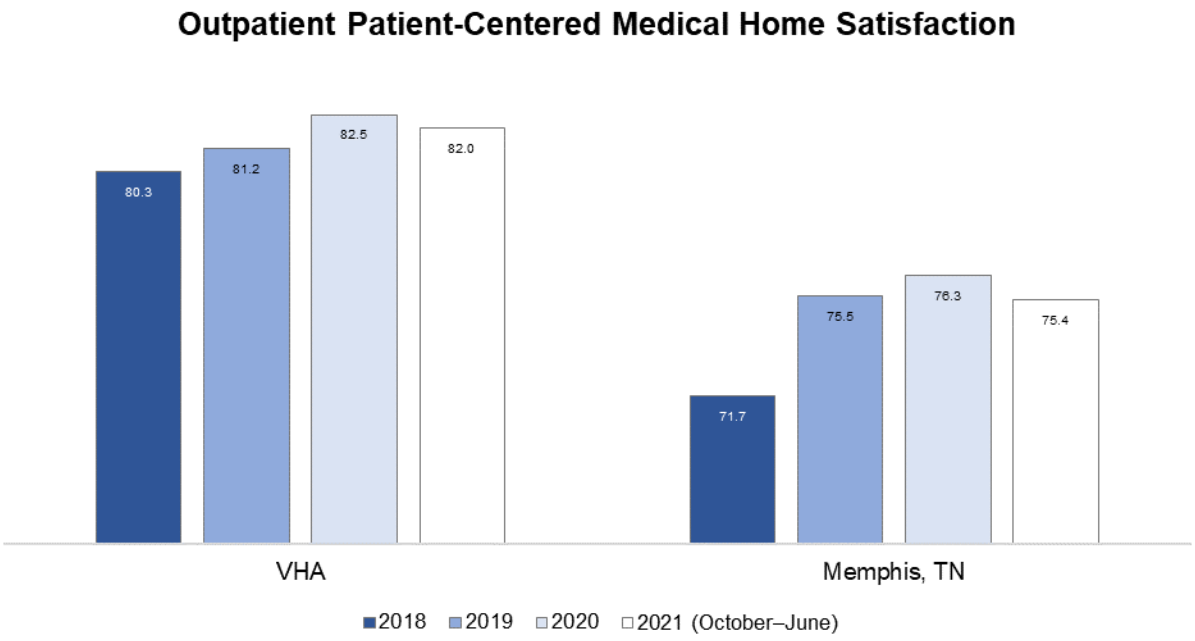

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 20, 2021).

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

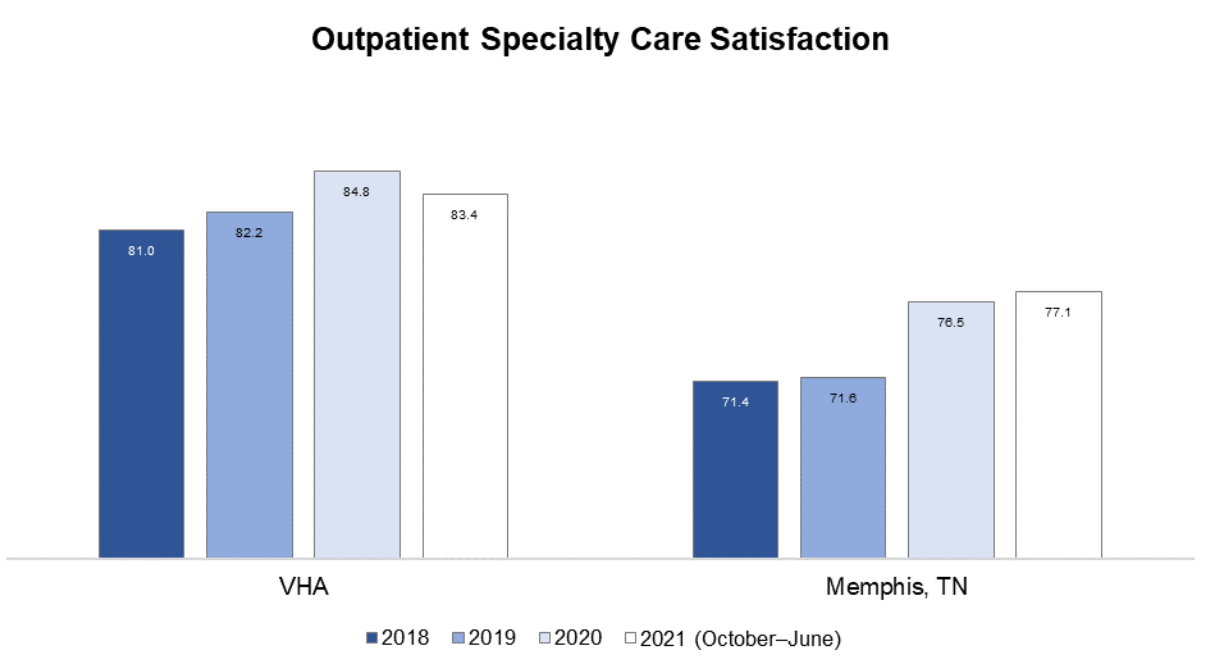

Figure 6. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 20, 2021).

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

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

Leaders must ensure that patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[20] 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."[21] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[22] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal

[20] 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/.

[21] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

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

representatives, that they may have been affected by an adverse event resulting from a systems issue."[23] 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 January 29, 2018 (the prior OIG CHIP site visit), to December 6, 2021.

Table 1. Summary of Selected Organizational Risk Factors (January 29, 2018, to December 6, 2021)

Factor	Number of Occurrences
Sentinel Events	11
Institutional Disclosures	5
Large-Scale Disclosures	0

Source: Memphis VA Medical Center's Patient Safety and Risk Managers (received on December 6, 2021, and updated on December 14, 2021).

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[24] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[25]

Executive leaders reported being informed of serious adverse patient events through the morning report process. The Chief of Quality Management and Performance Improvement stated that designated quality management staff reviewed adverse events daily and shared the information with nursing leaders prior to presenting the morning report to leaders. The Chief of Quality Management and Performance Improvement further reported that the Risk Manager reviewed sentinel events, and quality management staff tracked and trended related issues, which were then reviewed by the Quality, Safety and Value Board. The Interim Medical Center Director described a collaborative decision-making process with the Interim Chief of Staff and Risk Manager for determining when an institutional disclosure was warranted. The Interim Chief of Staff reported conducting electronic health record reviews and speaking with service chiefs to

[23] VHA Directive 1004.08.

[24] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

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

obtain additional information. The Interim Medical Center Director discussed how deaths were reviewed at the Mortality Committee meetings and reported to the Quality, Safety and Value Board.

The Patient Safety Manager provided details for 11 sentinel events, and the Risk Manager provided documentation for five institutional disclosures that occurred since the last OIG CHIP visit in 2018. Of the sentinel events reviewed, leaders conducted eight clinical disclosures and two institutional disclosures.[26] For the 1 remaining sentinel event, the Interim Medical Center Director and Risk Manager stated that the family notified medical center staff about this patient's death, and after a review of the event, the Interim Medical Center Director and Risk Manager concluded that an institutional disclosure was not warranted.

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG inspection, the leadership team consisted of three interim or acting executive leaders (Interim Medical Center Director, Interim Chief of Staff, and Acting ADPCS), in addition to the permanently assigned Associate Medical Center Director and newly hired Assistant Medical Center Director. The OIG interviewed the executive leaders and found that they had worked together for approximately four weeks. The OIG reviewed elements of budget and operations, employee satisfaction, and patient experience and found that executive leaders had opportunities to improve patient satisfaction.

While there are no recommendations in this section, the OIG remains concerned about continued leadership vacancies and patient satisfaction scores; the new leadership team will need to continue oversight and support so that sustainable improvement can be achieved.

[26] "Clinical disclosure of adverse events is a process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient's care." VHA Directive 1004.08.

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."[27] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain The Joint Commission accreditation.[28] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[29]

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 medical center'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 medical center's processes for conducting peer reviews of clinical care.[30] 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."[31] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[32]

Finally, the OIG assessed the medical center's culture of safety.[33] 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, peer reviews, patient safety reports, and other relevant information.

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

[28] 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.)

[29] VHA Directive 1100.16.

[30] 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.

[31] VHA Directive 1190.

[32] VHA Directive 1190.

[33] A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, accessed October 13, 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 made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[34] 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."[35]

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.[36] LIPs are granted clinical privileges for no more than two years and must be reprivileged prior to their expiration.[37]

VHA defines the Focused Professional Practice Evaluation as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[38] The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[39] 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.[40]

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.[41] 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

[34] 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.)
[35] VHA Handbook 1100.19.
[36] VHA Handbook 1100.19.
[37] VHA Handbook 1100.19.
[38] VHA Handbook 1100.19.
[39] VHA Handbook 1100.19.
[40] VHA Handbook 1100.19.
[41] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[42]

The OIG interviewed key managers and selected and reviewed the privileging folders of 35 medical staff members who had a Focused Professional Practice Evaluation or OPPE completed from October 1, 2020, through October 31, 2021.

Medical Staff Privileging Findings and Recommendations

VHA requires clinical privileges to be facility- and practitioner-specific, and service chiefs to establish additional criteria that are service-specific. These criteria are used for the ongoing monitoring of LIPs' clinical practices.[43] For 7 of 24 LIPs reprivileged, the OIG found that OPPE criteria were not specific to the service. When service chiefs do not evaluate LIPs on service-specific criteria, they may overlook specific practice deficiencies that could endanger patients.

The Acting Chief of Medicine reported that 4 LIPs were evaluated by other similarly privileged practitioners who reviewed patient records related to their specialty and believed this met requirements. However, the OIG observed that the criteria on the review forms were generic and not specific to the specialty or the practitioners' privileges. The Interim Chief of Staff reported requesting assistance from facilities where 2 of the LIPs were also privileged but was not able to provide the evidence used for the evaluations. Additionally, the Chief of Surgical Service reported that service-specific elements were part of 1 LIP's chart review but could not provide the documentation.

Recommendation 1

1. The Chief of Staff determines any additional reasons for noncompliance and makes certain that service chiefs include service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.

[42] 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.

[43] VHA Handbook 1100.19.

Medical Center concurred.

Target date for completion: March 31, 2023

Medical Center response: The Chief of Staff determined there were no additional reasons for noncompliance. In March 2022, the Clinical Practice Group (CPG), a workgroup of the Medical Executive Board (MEB), reviewed 100 percent of service Ongoing Professional Practice Evaluation (OPPE) forms to ensure service specific OPPE data was present. The CPG also approved service specific National Clinical Indicators to be used during Licensed Independent Practitioners (LIPs) chart reviews for all specialties in March 2022; the National Clinical Indicators contribute to the OPPE data. The MEB will audit 20 percent of completed OPPE forms monthly to ensure service specific data is used for LIP review until a 90 percent compliance rate is reached for six consecutive months.

VHA requires that, at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific OPPE data when recommending the continuation of LIPs' privileges to an executive committee of the medical staff (referred to as the Medical Executive Board at this medical center).[44] Such data are maintained as part of the LIPs' profiles and may include "direct observation, clinical discussions, and clinical pertinence reviews."[45]

For the 24 selected LIPs reprivileged, the OIG found that profiles lacked evidence that service chiefs recommended continuation of 4 LIPs' privileges based, in part, on OPPE data. The OIG identified similar concerns during the prior CHIP site visit in 2018.[46] This resulted in LIPs continuing to deliver care without thorough reviews of their practice, which may have affected safe patient care. The Interim Chief of Staff reported that service chiefs misunderstood the requirement to keep supporting OPPE documentation.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs' recommendations to continue licensed independent practitioners' privileges are based, in part, on Ongoing Professional Practice Evaluation data.

[44] For the time frame reviewed, November 1, 2020, through October 30, 2021, the committee minutes were titled Medical Executive Committee; however, the governance structure name was Medical Executive Board.

[45] VHA Handbook 1100.19.

[46] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Memphis VA Medical Center, Memphis, Tennessee*, Report No. 18-00609-185, June 19, 2018.

Medical Center concurred.

Target date for completion: March 31, 2023

Medical Center response: The Chief of Staff determined there were no additional reasons for noncompliance. Audits will be conducted of monthly meeting minutes from the Medical Executive Board (MEB) regarding service chiefs' recommendations to continue LIP's privileges based in part on OPPE data until a 90 percent compliance rate has been reached for six consecutive months. The Chief of Staff chairs the MEB.

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.[47] 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.[48] 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 community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[49]

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.[50] 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.[51]

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:

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[47] 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.)

[48] VHA Directive 1608.

[49] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

[50] 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.

[51] 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.

- Emergency Department
- Intensive care unit (medical)
- Medical/surgical inpatient unit (2S)
- Mental health inpatient units (1C and 1D)
- Outpatient clinic (5G)

Environment of Care Findings and Recommendations

The Joint Commission requires facilities to continually monitor environmental conditions and remediate those that do not meet standards.[52] Of the patient care areas inspected, the OIG observed two units with dusty air conditioning vents or stained ceiling tiles.[53] These issues could result in the lack of a safe and clean care environment. During the site visit, staff immediately cleaned the dusty air conditioning vents and replaced the stained ceiling tiles in the areas identified by the OIG inspector. The OIG also noted concerns with medication storage security, environment of care inspections, hazard warning signage for potentially infectious material, and camera use in patient care areas.

VHA requires staff to ensure that medications are stored in a secure manner and access is limited to authorized personnel who dispense or administer medications.[54] The OIG found that staff kept unit medications in a dispensing system at the nurses' station, and the refrigerator that stored medications as part of this dispensing system was unlocked and unmonitored on two separate occasions. This could allow unauthorized access to medications. According to the Nurse Manager, the unit had been closed for renovations for several months, and staff and patients returned to the unit just three days before the OIG site visit. The Nurse Manager further said that the refrigerator had not been reconnected and had to be manually locked; the interim plan included placing a work order and having authorized staff use a secured key to unlock the refrigerator as needed. The refrigerator was reconnected to the dispensing system during the site visit; therefore, the OIG made no recommendation.

VHA requires the medical center director to ensure that the facility has a comprehensive environment of care program, which includes staff conducting environment of care inspections at "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in patient

[52] *Standards Manual*, EC.04.01.01.

[53] The inpatient mental health areas (1C and 1D) and the Emergency Department had dusty air vents or stained ceiling tiles.

[54] VHA Directive 1108.06(2), *Inpatient Pharmacy Services*, February 8, 2017, amended August 26, 2021. (This directive was rescinded and replaced by VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022.)

care areas" and documenting completion of each inspection.[55] Additionally, VHA requires the comprehensive environment of care rounds coordinator to coordinate and schedule physical rounds at the facility and maintain inspection records.[56] Further, on March 20, 2020, a Deputy Under Secretary for Health for Operations and Management memorandum provided guidance regarding inspections in the context of the COVID-19 pandemic. This guidance allowed flexibility for facility staff to schedule inspections but mandated that they maintain documentation of decisions to delay inspections for future reference.[57]

The OIG found that staff did not inspect four community-based outpatient clinics twice in FY 2021.[58] Without conducting inspections, staff cannot proactively identify unsafe conditions. The Chief of Engineering Service could not provide documentation regarding the decision to delay the inspections in those areas, and the Safety Manager, who was not in the position during the period reviewed, explained that staff did not inspect the areas due to COVID-19 restrictions.

[55] VHA Directive 1608.

[56] VHA Directive 1608.

[57] "During periods when certain areas are restricted, the facility should consider scheduling rounds in areas that are not restricted until the restrictions are lifted. Where rounds in certain areas cannot be completed within the required time frame due to the COVID-19 emergency, facility leadership can consider postponing the rounds until the special restrictions/isolations due to the COVID-19 emergency have been lifted." VHA Deputy Under Secretary for Health for Operations and Management memo, "COVID-19 Guidance on Inspections, Fire Drills, and Routine Equipment Maintenance," March 20, 2020.

[58] The deficient areas included community-based outpatient clinics located in Helena, Arkansas; Jackson and Memphis (Union Avenue VA Clinic), Tennessee; and Tupelo, Mississippi.

Recommendation 3

3. The Medical Center Director determines any additional reasons for noncompliance and makes certain the Comprehensive Environment of Care Coordinator or designee schedules and ensures completion of environment of care inspections in patient care areas at the required frequency or maintains documentation to support pandemic-related postponement.

Medical Center concurred.

Target date for completion: March 31, 2023

Medical Center response: The Medical Center Director, in collaboration with the Associate Director, determined there were no additional reasons for noncompliance. Engineering now provides a monthly Environment of Care (EOC) update to the EOC Committee identifying construction/projects that are impacting areas where EOC rounds cannot be conducted. Additionally, EOC rounds frequency is tracked by the Safety and Occupational Health Specialist to confirm rounds were completed on schedule. Any deviation in the set schedule will also be reported to the EOC Committee monthly. In the event of emergency closings, the Medical Center Executive Leadership will notify the Safety Manager and EOC Coordinator to document that decision immediately and confirm that it is recorded in the EOC minutes. The target is for six consecutive months that 90% of the patient care areas will have their scheduled monthly inspection and if not, the appropriate documentation to support the related postponement will be present. The data will be documented in the EOC minutes and reported to the MCD [Medical Center Director] through the Executive Leadership Committee (ELC) minutes.

The Occupational Safety and Health Administration requires staff to post hazard warning signs on all access doors where potentially infectious materials are present; they must also affix warning signs to refrigerators that contain blood or other potentially infectious material.[59] The OIG identified several areas that lacked appropriate signage to indicate storage of potentially infectious materials, which could place patients, staff, and visitors at risk for exposure.[60] Medical center staff were unable to provide a reason for the lack of signage.

[59] According to the Occupational Safety and Health Administration's Bloodborne pathogens standard, "When potentially infectious materials…are present in the work area or containment module, a hazard warning sign incorporating the universal biohazard symbol shall be posted on all access doors. The hazard warning sign shall comply with paragraph (g)(1)(ii) of this standard." 29 C.F.R. § 1910.1030(e)(2)(ii)(D) and (g)(1)(ii). "Just Ask ASHE Clarification on Health Care Code Compliance" January 27, 2020, American Society for Health Care Engineering, accessed August 2, 2022, https://www.ashe.org/system/files/media/file/2020/02/2020-q1-just-ask-ashe.pdf.

[60] The OIG noted a lack of hazard warning signs in the medical/surgical inpatient unit (2S), Emergency Department point of care testing area, and on a laboratory specimen refrigerator in the medical/surgical inpatient unit (2S).

Recommendation 4

4. The Medical Center Director determines the reasons for noncompliance and ensures staff post signage in all areas where biohazards are present.[61]

Medical Center concurred.

Target date for completion: Completed

Medical Center response: The Medical Center Director, in collaboration with the Chief of Engineering and Safety Manager, evaluated and found no additional reasons for noncompliance. Areas with potentially infectious material were reviewed to ensure the presence of signage warning of biohazard exposure risks on access doors and on refrigerators. Biohazard signage was confirmed to have been placed in all applicable areas, including the areas specifically noted in this report. Those included the Medical/Surgical inpatient unit (2S), Emergency Department point of care testing area, and a laboratory specimen refrigerator in the Medical/Surgical inpatient unit (2S). This information was reported to the Executive Leadership Council on August 25, 2022.

VHA has established expectations to respect personal privacy by limiting when staff can take photographs, digital images, and video or audio recordings. As such, VHA requires the medical center director to collaborate with the chief of police, privacy officer, and chiefs of programs to "identify each area of the VA health care facility and [designate] each area as a treatment area, secure area, personal area, or other area, by posting signage or other notifications, and ensuring that signage or other notifications continue to be posted, as needed."[62] VHA further requires signage and specifies certain modes of recording in each type of area. For patient care areas, VHA allows staff to use video recordings for official or treatment purposes with appropriate informed consent. If the purpose of the camera in the treatment area is for patient safety, cameras are to be used for monitoring (no recording) and "must only be accessed and viewed by staff who are both responsible for ensuring the safe delivery of care and authorized to take action based on the monitoring." In areas designated as secure and personal, signage must be present indicating the area "may be subject to photography, digital imaging or video or audio recording."[63]

The OIG found that medical center leaders had not designated areas as required and was therefore unable to determine their compliance related to signage and use of cameras in the three areas evaluated. For the medical intensive care unit inspected, the OIG found that four patient

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

[62] VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021.

[63] VHA Directive 1078.

care rooms located farthest from the nurse's station had cameras that did not record but were monitored by unit staff, who explained the cameras were for patient safety.

The OIG also found that the Emergency Department had cameras located in four patient care rooms that staff identified as an area for mental health patients. These cameras were monitored by both Emergency Department staff and VA Police. The cameras' recordings remained in the Police Service record for approximately two weeks, according to the Chief of Police. No signage was posted in the area regarding monitoring and recording of these rooms.

The mental health inpatient units (1C and 1D) had cameras throughout the units, including common areas (laundry, dining rooms, outside picnic areas, and hallways) and seclusion rooms. The camera system recorded video, and according to the Mental Health Nurse Manager, the system retained the recordings for about 30 days. The OIG conducted a spot check and found recordings dating back 49 days. The cameras were monitored only by mental health staff and were not tied into the VA Police Service system. The units had no signage about video recording.

The OIG is concerned because these situations could result in patients not being informed of camera use in care areas. The Mental Health Nurse Manager reported that the unit did have signs, but they had not been replaced after recent renovations. The other medical center leaders were unable to provide a reason the areas had not been designated as either treatment, secure, personal, or other and could not explain the lack of signage or why the use of cameras was inconsistent with VHA privacy requirements.

Recommendation 5

5. The Medical Center Director determines the reasons for noncompliance and ensures the Chief of Police, Privacy Officer, and chiefs of programs identify medical center areas as a treatment, secure, personal, or other area.[64]

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

Medical Center concurred.

Target date for completion: Completed

Medical Center response: The Medical Center Director (MCD) evaluated additional reasons for noncompliance, and none were identified. The MCD convened a workgroup of the Privacy Officer, Public Affairs Officer, Chief of Police, Chief of Mental Health Service, Chief of Quality Management and Performance Improvement, Emergency Department Service Chief and Critical Care Service Chief. This workgroup identified those Medical Center areas that were designated as either a treatment, secure, personal, or other area. A list was developed of those designations based on VHA Directive 1078, and it identified appropriate camera usage and signage for each area based on whether it is treatment, secure, personal, or other. This list was provided to the MCD in a Memo dated August 16, 2022. The list was also presented to the Environment of Care Committee on August 23, 2022, as part of an annual review of area designations and determination of signage for notification of informed consent. The information was presented to the Executive Leadership Council on August 25, 2022.

Recommendation 6

6. The Medical Center Director determines the reasons for noncompliance and ensures leaders comply with VHA requirements for signage and camera-recording, based on area designations.

Medical Center concurred.

Target date for completion: December 31, 2022

Medical Center response: The Medical Center Director evaluated additional reasons for noncompliance, and none were identified. The Medical Center Director convened a workgroup of the Privacy Officer, Chief of Police, Public Affairs Officer, Chief of Mental Health Service, Chief of Quality Management and Performance Improvement, Chief Emergency Department and Critical Care Service Chief. This workgroup identified the Medical Center areas that were designated as either treatment, secure, personal, or other area. A list of all areas was developed of those designations based on VHA Directive 1078, and it identified appropriate camera usage and signage for each area based on whether it is treatment, secure, personal, or other. That list was provided to the MCD on August 16, 2022. Placement of signage was confirmed also for areas noted in this report with cameras, including four patient rooms in the MICU [medical intensive care unit], four mental health patient rooms in the Emergency Department, and the inpatient mental health unit (1C/1D). This list was presented to the Environment of Care Committee on August 23, 2022, as part of an annual review for maintaining appropriate notification signage for monitoring and/or recording use of cameras. The workgroup also confirmed that the video equipment that is present in the mental health inpatient units (1C and 1D) erased all recordings past 28 days. Recordings from the four rooms in the Emergency Department were confirmed to be erased every 30 days. The information was reported to the Executive Leadership Council on August 25, 2022. Temporary signage has been placed awaiting ordered permanent signage.

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 among U.S. adults."[65] 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."[66]

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 when the screen is positive.[67] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation 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."[68] The OIG assessed the medical center for its adherence to staff completion of suicide safety plans prior to patients' 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 key employees and managers and reviewed the electronic health records of 50 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 made no recommendations.

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[65] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

[66] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*.

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

[68] 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.

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 medical center, the OIG conducted a detailed review and issued six recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this medical center. 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 six OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Medical Center Director and Chief of Staff. 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 health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs include service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners. • Service chiefs' recommendations to continue licensed independent practitioners' privileges are based, in part, on Ongoing Professional Practice Evaluation data.
Environment of Care	• The Comprehensive Environment of Care Coordinator or designee schedules and ensures completion of environment of care inspections in patient care areas at the required frequency or maintains documentation to support pandemic-related postponement. • Staff post signage in all areas where biohazards are present. • The Chief of Police, Privacy Officer, and chiefs of programs identify medical center areas as a treatment, secure, personal, or other area. • Leaders comply with VHA requirements for signage and camera-recording, based on area designations.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• None

Appendix B: Medical Center Profile

The table below provides general background information for this highest complexity (1a) affiliated medical center reporting to VISN 9.[1]

Table B.1. Profile for Memphis VA Medical Center (614)
(October 1, 2018, through September 30, 2021)

Profile Element	Medical Center Data FY 2019*	Medical Center Data FY 2020†	Medical Center Data FY 2021‡
Total medical care budget	$521,733,655	$655,233,350	$728,403,466
Number of:			
• Unique patients	65,023	57,219	65,762
• Outpatient visits	670,733	610,159	652,470
• Unique employees§	2,101	2,136	2,067
Type and number of operating beds:			
• Domiciliary	26	26	26
• Intermediate	18	18	18
• Medicine	60	60	60
• Mental health	32	32	32
• Neurology	5	5	5
• Spinal cord	60	60	60
• Surgery	20	20	20
Average daily census:			
• Domiciliary	23	10	6
• Intermediate	13	10	7
• Medicine	44	52	61
• Mental health	25	17	20
• Neurology	1	0	–
• Spinal cord	15	4	3

[1] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high volume, high risk patients, most complex clinical programs, and large research and teaching programs." "Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing. An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2019*	Medical Center Data FY 2020†	Medical Center Data FY 2021‡
Average daily census (cont.):			
• 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 29, 2022

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

Subj: Comprehensive Healthcare Inspection of the Memphis VA Medical Center in Tennessee

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

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

1. I have reviewed the findings and recommendations in the OIG report entitled, Draft Report: Comprehensive Healthcare Inspection of the Memphis VA Medical Center in Tennessee. I concur with the action plans submitted by the Memphis VA Medical Center Director.
2. We thank the OIG for the opportunity to review and respond to the Draft Report: Comprehensive Healthcare Inspection of the Memphis VA Medical Center in Tennessee.

(Original signed by:)
Gregory Goins, FACHE
Network Director, VISN 9

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: August 26, 2022

From: Medical Center Director, Memphis VA Medical Center (614/00)

Subj: Comprehensive Healthcare Inspection of the Memphis VA Medical Center in Tennessee

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

Attached please find the VA Medical Center at Memphis, Tennessee's response and action plans to the Draft Report of the Office of Inspector General Comprehensive Healthcare Inspection Program (OIG CHIP) conducted the week of December 5, 2021.

(Original signed by:)

Joseph P. Vaughn, MBA, FACHE

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