



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the Mountain
Home VA Healthcare
System in Tennessee



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Figure 1. Mountain Home VA Healthcare System in Tennessee.

Source: <https://www.va.gov/mountain-home-health-care>.

Abbreviations

ADPCS	Associate Director of Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
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 Mountain Home VA Healthcare System, which includes the James H. Quillen VA Medical Center and multiple outpatient clinics in Tennessee and Virginia. 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 performs the inspections approximately every three years for each facility 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 Mountain Home VA Healthcare System from December 6 through December 20, 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 finding presented in this report is a snapshot of the healthcare system's performance within the identified focus area at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the finding 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 an opportunity for improvement in one of the areas reviewed and issued one recommendation to the System Director. This opportunity for improvement is briefly described below.

Leadership and Organizational Risks

The OIG reviewed executive leadership position stability and found that leaders had worked together for over three years. The healthcare system's fiscal year 2021 annual medical care budget had increased over 9 percent compared to the previous year's budget. The Director reported that the budget increase supported a plan to increase staff and expand inpatient bed capacity and outpatient services.

The OIG also reviewed All Employee Survey results and concluded that the Director had an opportunity to improve staff's perceived ability to disclose suspected violations without fear of reprisal. Patient experience survey scores generally reflected higher care ratings than the VHA averages but trended downward in primary care from 2019 through 2021. The OIG's review of patient safety events did not identify any substantial organizational risk factors. However, the OIG noted concerns with system leaders identifying sentinel events.¹

Conclusion

The OIG conducted a detailed inspection across five key areas and subsequently issued one recommendation for improvement to the System 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 the system leader to use the recommendation as a road map to help improve operations and clinical care. The recommendation addresses a systems issue that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, pages 24-25, and the response within the body of the report for the full text of the directors' comments). The OIG considers the recommendation closed.



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¹ A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and [where] intervention [is] required to sustain life." VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

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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 Mountain Home VA Healthcare System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.¹

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

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

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on 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 Mountain Home VA Healthcare System includes the James H. Quillen VA Medical Center and associated outpatient clinics in Tennessee and Virginia. General information about the healthcare system can be found in appendix B.

The inspection examined operations from November 26, 2018, through December 20, 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 recommendation for improvement addresses a problem that can influence the quality of patient care significantly enough to warrant OIG follow-up until the system leader completes corrective actions. The Director's response to the report recommendation appears within the topic area. The OIG accepted the action plan that the leader developed based on the reason 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 James H. Quillen VA Medical Center occurred in November 2018, while The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in January 2020.

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 System Director (Director), Associate Director, Chief of Staff, and Associate Director of Patient Care Services (ADPCS). 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 worked together for over three years. The Chief of Staff was assigned in 2012, while the Director and ADPCS had served in their roles since 2017. The Associate Director was assigned in October 2018. To help assess the executive leaders’ engagement, the OIG interviewed the Director, acting Chief of Staff, ADPCS, and

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.

Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.¹⁰

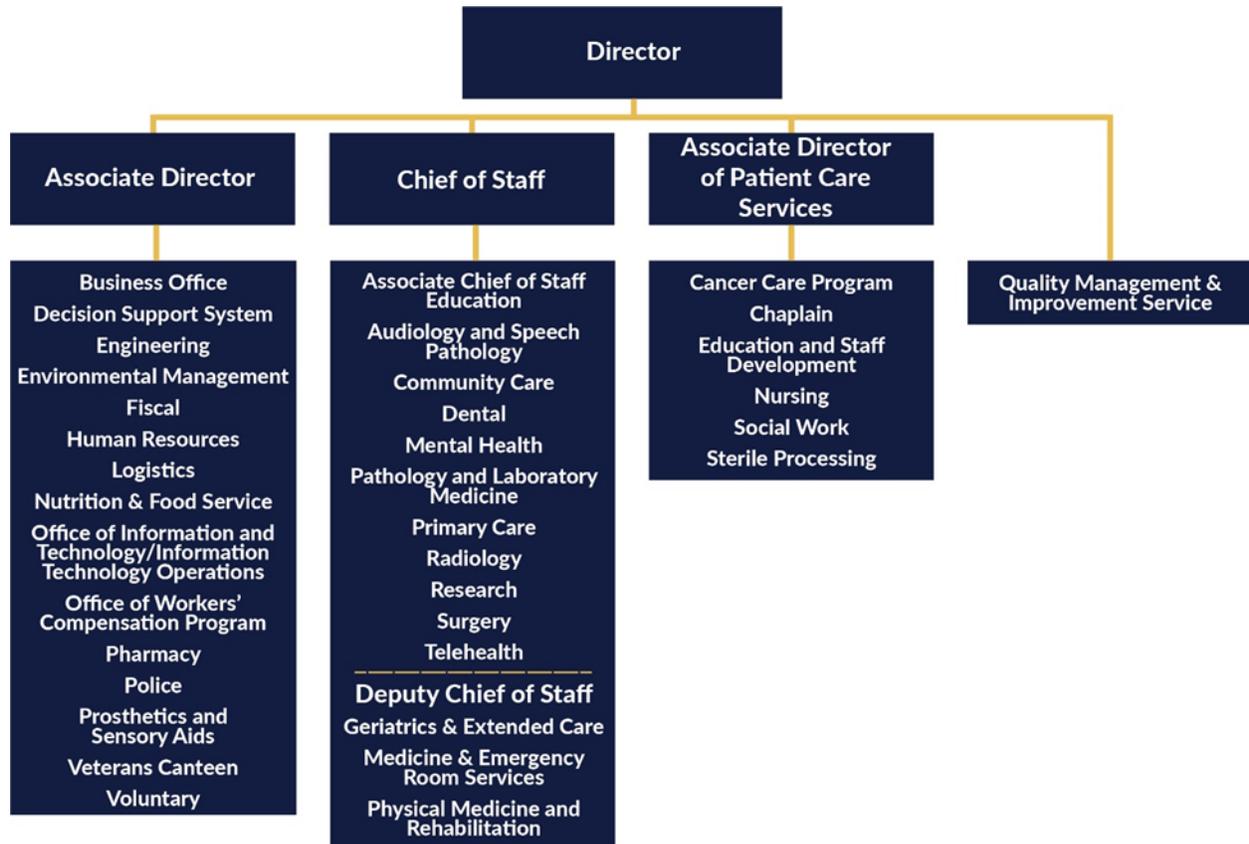


Figure 2. Healthcare system organizational chart.

Source: Mountain Home VA Healthcare System (received December 6, 2021).

Budget and Operations

The OIG noted the healthcare system’s fiscal year (FY) 2021 annual medical care budget of \$728,522,964 had increased over 9 percent compared to the previous year’s budget of \$665,564,393.¹¹ The Director reported that the budget increase supported a plan for a 10 percent growth in staff over a three-year period and the expansion of total inpatient bed capacity from 60 to 80 beds, with a surge capacity of 90.

The Director also detailed that they were expanding the Knoxville outpatient clinic’s occupational therapy, physical therapy, and dermatology services to reach 30,000 veterans in that area. The Director added that they had expanded gynecology, dermatology, and women’s health

¹⁰ At the time of the inspection, the Chief of Staff was on leave; therefore, the OIG interviewed the acting Chief of Staff.

¹¹ VHA Support Service Center (VSSC).

services in a rural clinic and leased the Morristown outpatient clinic to provide primary and mental health care and physical therapy services. The Director further reported that the sleep clinic and radiation oncology services had reopened, and a second radiation oncology care team had been hired; the intensive care unit was renovated with telemedicine capabilities; and the system added medical partnerships with the University of Tennessee and Meharry Medical College.

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. 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 system leaders and the workplace, the OIG reviewed results from VHA’s All Employee Survey from FY 2019 to 2021 regarding employees’ perceived ability to disclose a suspected violation without fear of reprisal.¹³ The OIG found that the healthcare system and leaders’ averages were mostly similar to VHA averages. The system’s scores, as well as those for the ADPCS, trended upward over the three-year period while the Associate Director’s scores were sustained. However, the Director’s scores trended downward. The Director reported having challenges with some of the staff and still trying to learn the VA culture.

¹² “AES Survey History, Understanding Workplace Experiences in VA,” VSSC website.

¹³ 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. The 2019 through 2021 All Employee Survey results are not reflective of employee satisfaction with the acting Chief of Staff.

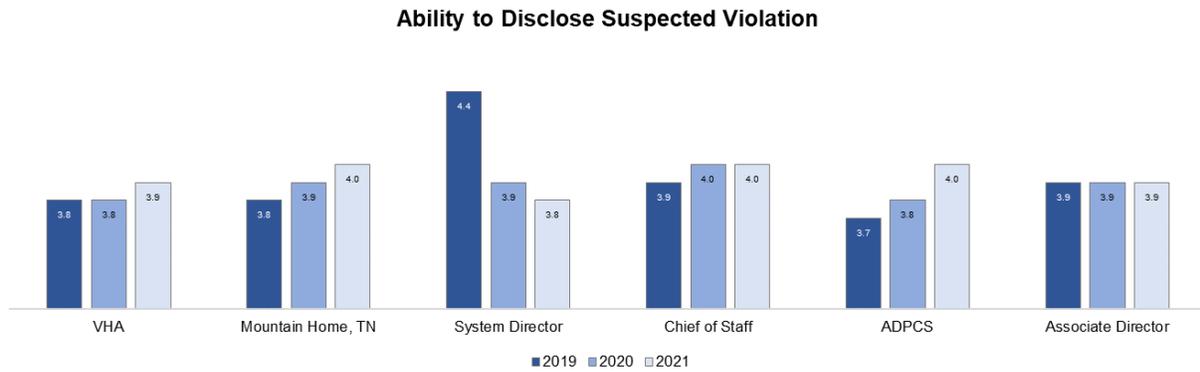


Figure 3. All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.

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 its performance against the private sector. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.¹⁴

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.¹⁵ The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from October 2017 (FY 2018), through June 2021. Figures 4–6 provide survey results for VHA and the healthcare system over time.¹⁶

¹⁴ “Patient Experiences Survey Results,” VSSC website.

¹⁵ “Patient Experiences Survey Results,” VSSC website.

¹⁶ Scores are based on responses by patients who received care at this healthcare system.

The healthcare system’s inpatient satisfaction survey results consistently reflected higher scores than VHA averages. The Director stated that higher scores were due to leaders treating employees well, which in turn resulted in staff taking positive risks, being enthusiastic and innovative, and providing better customer service.

The acting Chief of Staff reported taking three steps to improve scores: adding Survey of Healthcare Experiences of Patients scores to service chiefs’ performance plans, requiring providers to sit when speaking with patients, and increasing public affairs officers’ outreach. Additionally, the acting Chief of Staff reported regularly distributing patient compliments to staff, increasing social media presence and texting to patients, providing media interviews, and sharing positive veteran stories as reasons for the high satisfaction rate. The ADPCS attributed the system’s patient satisfaction scores to hiring good nurses and providing them with needed tools and education. Furthermore, the ADPCS reported that nurses were kind and personalized their care to the patient, and these efforts were reflected in the scores.

Inpatient Recommendation

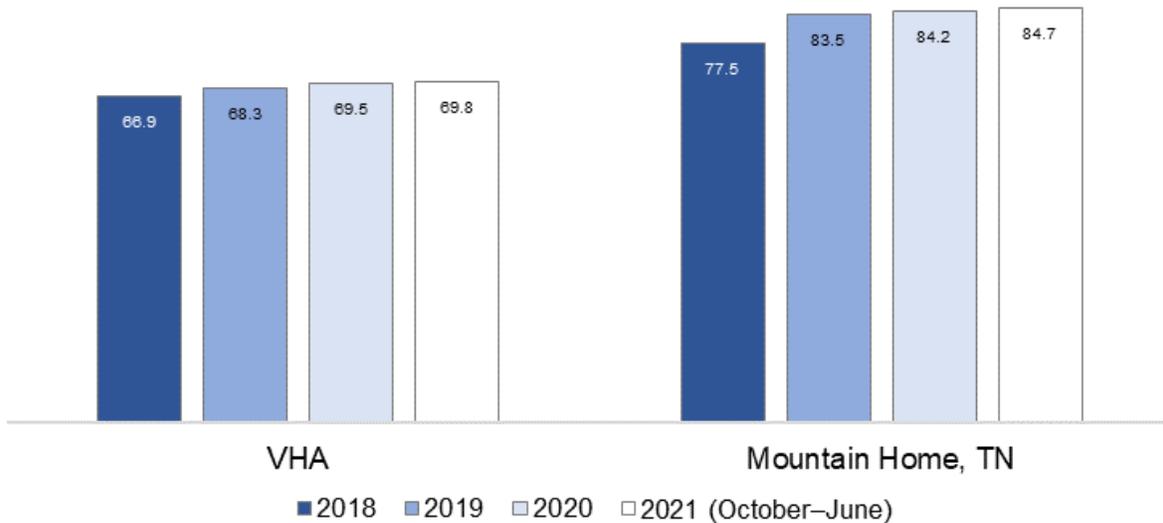


Figure 4. Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?

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 also consistently reflected higher scores than the VHA averages; the Director stated that everything system leaders do is for the veterans. However, the OIG noted that the system’s primary care results trended downward from FY 2019 through 2021. The ADPCS reported that working in primary care was difficult, but nurses took ownership of their patients. Additionally, the ADPCS stated that nurses returned patient phone calls in a timely manner to improve patient experiences.

Outpatient Patient-Centered Medical Home Satisfaction

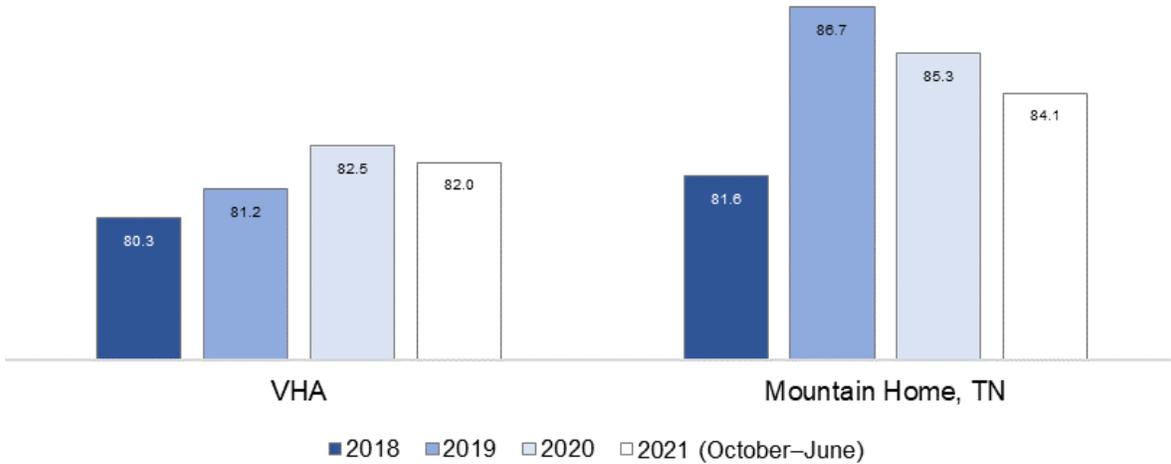


Figure 5. A Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?

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

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

The healthcare system’s outpatient specialty care patient satisfaction survey results generally reflected higher scores than the VHA averages. The system’s scores trended upward over four years. The Director reported that leaders had expanded gynecology, dermatology, and women’s health services at a rural clinic and planned to expand primary care, mental health, and physical therapy services at another clinic. The ADPCS stated that the system had very good specialists, and that staff members tried to do the right thing.

Outpatient Specialty Care Satisfaction

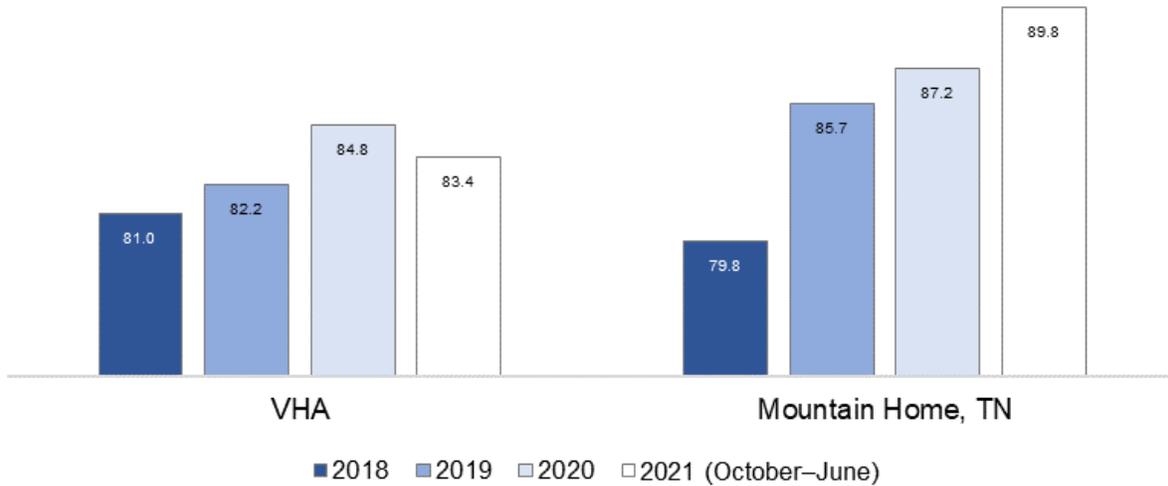


Figure 6. A Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 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 health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.¹⁷ 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.”¹⁸ 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.”¹⁹ 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.”²⁰ 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 November 26, 2018 (the prior OIG CHIP site visit), through December 5, 2021.

Table 1. Summary of Selected Organizational Risk Factors (November 26, 2018, through December 5, 2021)

Factor	Number of Occurrences
Sentinel Events	1
Institutional Disclosures	8
Large-Scale Disclosures	0

Source: Mountain Home VA Healthcare System Patient Safety Manager and Risk Manager (received December 6, 2021).

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission’s (TJC’s) standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.²¹ A VA medical facility’s culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

¹⁷ 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/>.

¹⁸ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

¹⁹ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

²⁰ VHA Directive 1004.08.

²¹ The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.²² The Director reported spending a large amount of time on quality, safety, and value-related issues and described a robust patient safety program. Additionally, the Director stated that the VISN Quality Management Officer had been helpful with quality-related issues. While the system's one reported sentinel event met the corresponding TJC definition and an institutional disclosure was completed, the OIG had concerns related to leaders identifying additional sentinel events. These concerns are discussed in greater detail below.

Leadership and Organizational Risks Findings and Recommendations

The OIG interviewed executive leaders, who had worked together for over three years. The OIG reviewed employee satisfaction data, which revealed the Director had an opportunity to improve scores for staff's perceived ability to disclose a suspected violation. Additionally, the OIG noted concerns related to leaders identifying sentinel events.

TJC defines sentinel events as patient safety events that result in death or severe temporary or permanent harm.²³ Leaders are accountable for identifying sentinel events, conducting a review to determine the root cause, and implementing actions to prevent future occurrences.²⁴ The OIG reviewed the eight institutional disclosures of adverse events conducted from November 26, 2018, through December 5, 2021, and found that leaders did not identify seven of the events as sentinel, even though they met TJC's definition.²⁵ Failure to identify sentinel events may lead to missed opportunities for leaders to recognize safety trends or mitigate future risks.

The Director stated that patient safety events were shared in written morning reports, through emails from the Patient Safety Manager and Chief Quality Manager, and during committee meetings. The Director also stated that executive leaders were aware of TJC's sentinel event definition, discussed patient incidents in comparison to other facilities, and determined which events they believed met sentinel event criteria. The Patient Safety Manager reported tracking patient safety events that met the TJC criteria and forwarding them to the Chief Quality Manager. The Director, ADPCS, Chief Quality Manager, and Patient Safety Manager confirmed

²² Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

²³ The Joint Commission, *Sentinel Events (SE)*, Comprehensive Accreditation Manual for Hospitals, January 2021, accessed March 2, 2021, <https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-policy-and-procedures/>.

²⁴ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

²⁵ The institutional disclosures of adverse events included patient deaths and unnecessary invasive procedures and chemotherapy.

that possible sentinel events were discussed in meetings with the executive leadership team, who made the final determination.

Recommendation 1

1. The System Director determines the reasons for noncompliance and ensures leaders identify adverse events as sentinel events when criteria are met.²⁶

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. The Patient Safety Manager developed a tracking tool and reviewed all adverse events entered in the Joint Patient Safety Reporting system to determine if sentinel event criteria were met according to The Joint Commission sentinel event and VHA National Patient Safety Handbook criteria. The Patient Safety Manager appropriately designated and reported all adverse events meeting the sentinel event criteria to the Chief Quality Manager. The Chief Quality Manager reviewed all sentinel events with the executive leadership team. The Patient Safety Manager maintained a list of all identified sentinel events.

The Patient Safety Manager monitored compliance with proper designation of sentinel events until a 90 percent compliance rate was demonstrated for six consecutive months. The numerator was the number of adverse events properly identified as sentinel events and the denominator was the number of adverse events meeting the Joint Commission sentinel event and VHA National Patient Safety Handbook criteria. From January 1, 2022, through June 30, 2022, there was 100 percent compliance each month.

²⁶ The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

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 its facilities to implement programs to monitor the quality of patient care and performance improvement activities and maintain TJC accreditation.²⁸ Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from TJC).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 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.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 healthcare system’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 healthcare system was assessed for its performance on several dimensions related to adverse patient safety events.

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 3, 2022, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf>.

The OIG reviewer interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

Quality, Safety, 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 repriviledged 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 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, *Credentialing of Health Care Providers*, September 15, 2021.

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 several medical staff members:

- One solo practitioner who underwent clinical privileging in the previous 12 months⁴³
- Ten LIPs who had a Focused Professional Practice Evaluation completed in the previous 12 months
- Twenty LIPs who were repriviledged in the previous 12 months

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

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 refers to a solo practitioner as being one provider in the facility who is privileged in a particular specialty. VHA 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 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).

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.⁴⁴ 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.⁴⁵

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.⁴⁶ 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.⁴⁷

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 15 patient care areas:

- Ambulatory surgery clinic
- Community living center (1st and 2nd)

⁴⁴ 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.)

⁴⁵ VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

⁴⁶ Centers for Disease Control and Prevention – National Center for Health Statistics, “Drug Overdose Deaths in the U.S. Top 100,000 Annually,” accessed December 6, 2021, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

⁴⁷ 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.

- Dental clinic
- Emergency department
- Intensive care unit
- Medical/surgical inpatient units (C 1st and C 2nd)
- Mental health inpatient unit
- Mental health outpatient unit (E 2nd)
- Post-anesthesia care unit (building 200, D Ground)
- Primary care clinic (primary care buildings 160N and 160P)
- Step-down telemetry unit
- Women's health clinic

Environment of Care Findings and Recommendations

The OIG made no recommendations.

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.”⁴⁸ 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.”⁴⁹

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 screening is positive.⁵⁰ 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.”⁵¹ The OIG assessed the healthcare system for its adherence to staff’s 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 reviewed the electronic health records of 44 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.

⁴⁸ Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

⁴⁹ Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*.

⁵⁰ 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.

⁵¹ 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 healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided one recommendation on a systemic issue that may adversely affect patients. The recommendation does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's finding illuminates an area of concern, and the recommendation may help guide improvement efforts. The recommendation is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines one OIG recommendation aimed at reducing a vulnerability that may lead to patient safety issues or adverse events. The recommendation is attributable to the System Director. The intent is for this leader to use the recommendation as a road map to help improve operations and clinical care. The recommendation addresses a systems issue 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	<ul style="list-style-type: none"> • Leaders identify adverse events as sentinel events when criteria are met.
Quality, Safety, and Value	<ul style="list-style-type: none"> • None
Medical Staff Privileging	<ul style="list-style-type: none"> • None
Environment of Care	<ul style="list-style-type: none"> • None
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	<ul style="list-style-type: none"> • None

Appendix B: Healthcare System Profile

The table below provides general background information for this mid-high complexity (1c) affiliated healthcare system reporting to VISN 9.¹

**Table B.1. Profile for Mountain Home VA Healthcare System (621)
(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	\$506,965,243	\$665,564,393	\$728,522,964
Number of:			
• Unique patients	61,221	61,191	63,297
• Outpatient visits	788,666	766,286	852,288
• Unique employees§	2,250	2,298	2,397
Type and number of operating beds:			
• Community living center	120	120	70
• Domiciliary	150	150	88
• Medicine	56	56	56
• Mental health	24	24	24
• Surgery	16	16	16
Average daily census:			
• Community living center	82	57	36
• Domiciliary	120	77	49
• Medicine	45	44	52
• Mental health	19	17	16

¹ VHA medical facilities are classified according to a complexity model; a designation of “1c” indicates a facility with “medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs.” “Facility Complexity Level 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‡
Average daily census cont.: <ul style="list-style-type: none"> • Surgery 	7	5	5

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

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

**October 1, 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 22, 2022

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

Subj: Comprehensive Healthcare Inspection of the Mountain Home VA Healthcare System in Tennessee

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

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

1. I have reviewed the finding and recommendation in the OIG report entitled, Draft Report: Comprehensive Healthcare Inspection of the Mountain Home VA Healthcare System in Tennessee. I concur with the action plan submitted by the Mountain Home 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 Mountain Home VA Healthcare System in Tennessee.

(Original signed by:)

Gregory Goins, FACHE
Network Director, VISN 9

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: August 22, 2022

From: Director, Mountain Home VA Healthcare System (621/00)

Subj: Comprehensive Healthcare Inspection of the Mountain Home VA Healthcare System in Tennessee

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

1. Thank you for the opportunity to review and respond to the Draft Report Comprehensive Healthcare Inspection of the Mountain Home VA Healthcare System in Tennessee. I concur with the finding and recommendation.
2. Our response to the report recommendation is attached. We have been actively working on improvements. We appreciate the perspective from the Office of Inspector General evaluation and will take this opportunity to strengthen and improve our medical center processes.

(Original signed by:)

Dean B. Borsos, MHSA, FACHE
Medical Center Director

OIG Contact and Staff Acknowledgments

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