DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Amarillo VA Health Care System in Texas

CHIP REPORT | REPORT #22-00036-68 | MARCH 15, 2023

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Figure 1. *Amarillo VA Health Care System in Texas.*
Source: https://www.va.gov/amarillo-health-care/.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
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 Amarillo VA Health Care System and associated outpatient clinics in Texas and New Mexico. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

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

The OIG conducted an unannounced virtual inspection of the Amarillo VA Health Care System from January 10 through January 14, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement and issued three recommendations to the Chief of Staff in the Medical Staff Privileging area of review. These results are detailed in the report section and summarized in appendix A on page 21.

Conclusion

The OIG issued three recommendations for improvement to the Chief of Staff. The number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for this leader 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 Healthcare System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 23–24, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

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

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

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

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

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae 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 Amarillo VA Health Care System includes the Thomas E. Creek VA Medical Center and associated outpatient clinics in Texas and New Mexico. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from January 19, 2019, through January 14, 2022, the last day of the unannounced multiday evaluation.[5] During the virtual visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Director's responses to the report recommendations appear within the 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 Amarillo VA Health Care System occurred in January 2019. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in January 2020 and laboratory reviews in January (Lubbock VA Clinic) and April (healthcare system) 2021.

[6] Inspector General (IG) Act of 1978, as amended, Pub. L. No. 117-286, § 3(b), 136 Stat. 4196, 4206 (2022) (to be codified at 5 U.S.C. §§ 401–24).

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's executive leadership team consisted of the Director, Associate Director, Chief of Staff, and Nurse Executive. The Chief of Staff and Nurse Executive oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive leaders had worked together for about one month since the Chief of Staff joined in December 2021. The Director, Nurse Executive, and Associate Director had been in their roles since 2020. To help assess the executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Nurse Executive, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

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[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.

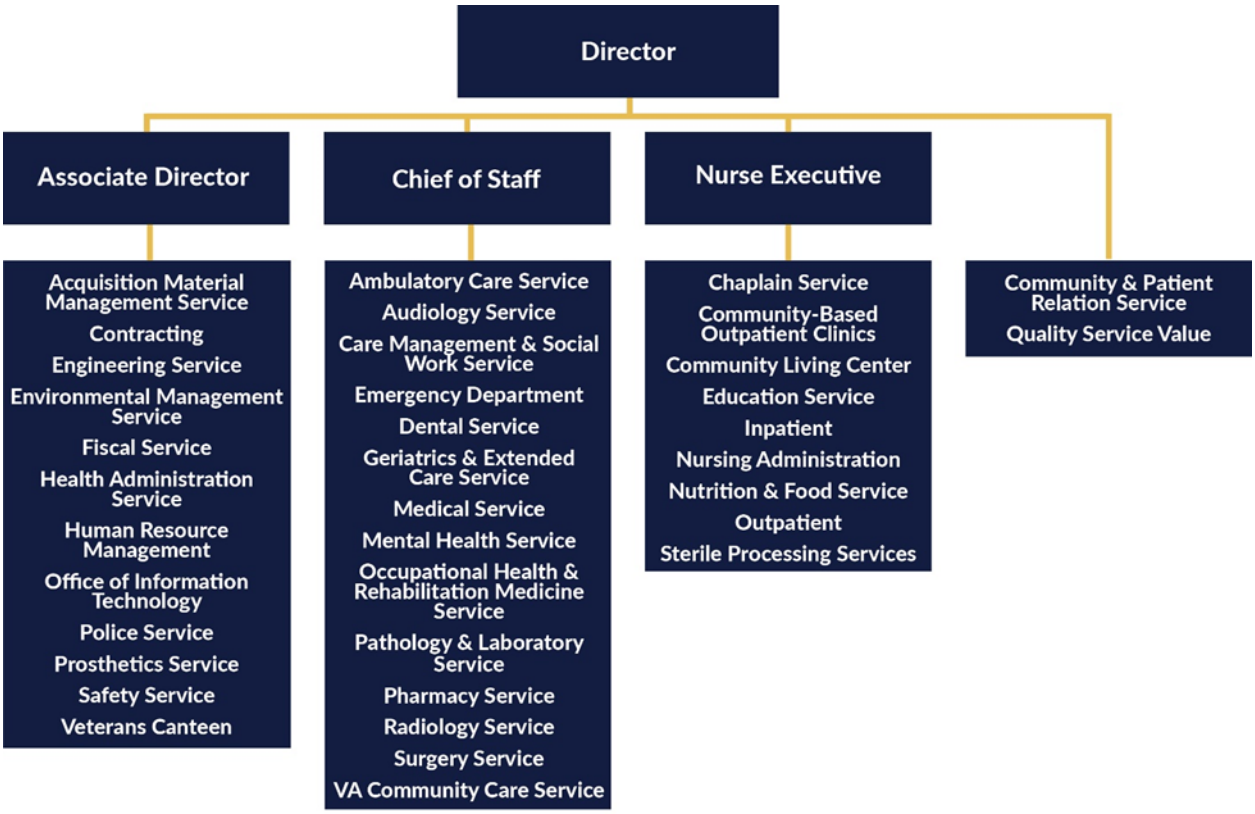

Figure 2. *Healthcare system organizational chart.*

Source: Amarillo VA Health Care System (received January 10, 2022).

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $352,818,091 had increased by nearly 4 percent compared to the previous year's budget of $339,280,988.[10] The Director and Associate Director similarly stated that the increase allowed the executive leaders to assign staffing ceilings to each service line, which gave service chiefs more flexibility and autonomy in filling vacant positions. The Director also mentioned opening a new inpatient unit in FY 2021.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] 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

[10] VHA Support Service Center (VSSC).

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

discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

To assess employee attitudes toward healthcare system leaders and the workplace, the OIG reviewed results from Veterans Health Administration's (VHA's) All Employee Survey from FYs 2019 to 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[12] Healthcare system and executive leader averages were similar to or better than VHA averages. The Director attributed the positive results to treating employees with dignity and respect. The Nurse Executive indicated that executive leaders were working with an internal consultant who specialized in organizational development, and they were one year into their high reliability organization journey.[13]

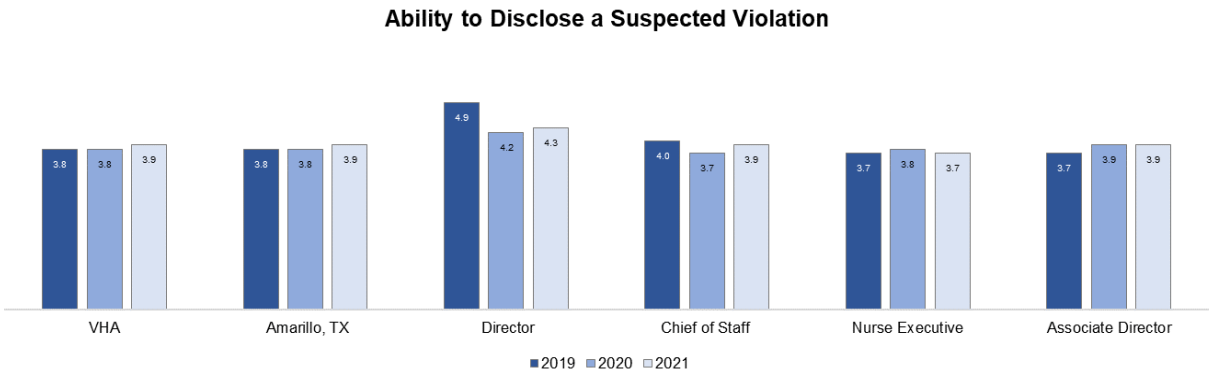

Figure 3. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed December 6, 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.[14]

[12] The OIG makes no comment on the adequacy of the VHA average for the selected survey element. The VHA average is used for comparison purposes only. The 2020 All Employee Survey results are not fully reflective of employee satisfaction with the current Director and Nurse Executive, nor are the 2021 results reflective of the current Chief of Staff because of the dates the leaders assumed their roles.

[13] A high reliability organization is an "organization with a goal of achieving 'zero harm' in an environment where accidents are expected due to complexity or risk factors." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

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

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 1, 2017 (FY 2018), through August 31, 2021. Figures 4–6 provide survey results for VHA and the healthcare system over time.[16]

The healthcare system's inpatient satisfaction survey results were similar to or more favorable than the VHA averages. The Director attributed the improved score in FY 2021 to a new inpatient unit. The Chief of Staff added that the system had qualified staff who were veteran-centered in their approach, resulting in patients' increased trust in the VA care provided. The Nurse Executive also reported hiring a wound care nurse in response to veterans' concerns, which contributed to a significant reduction of adverse wound events in the acute care setting.

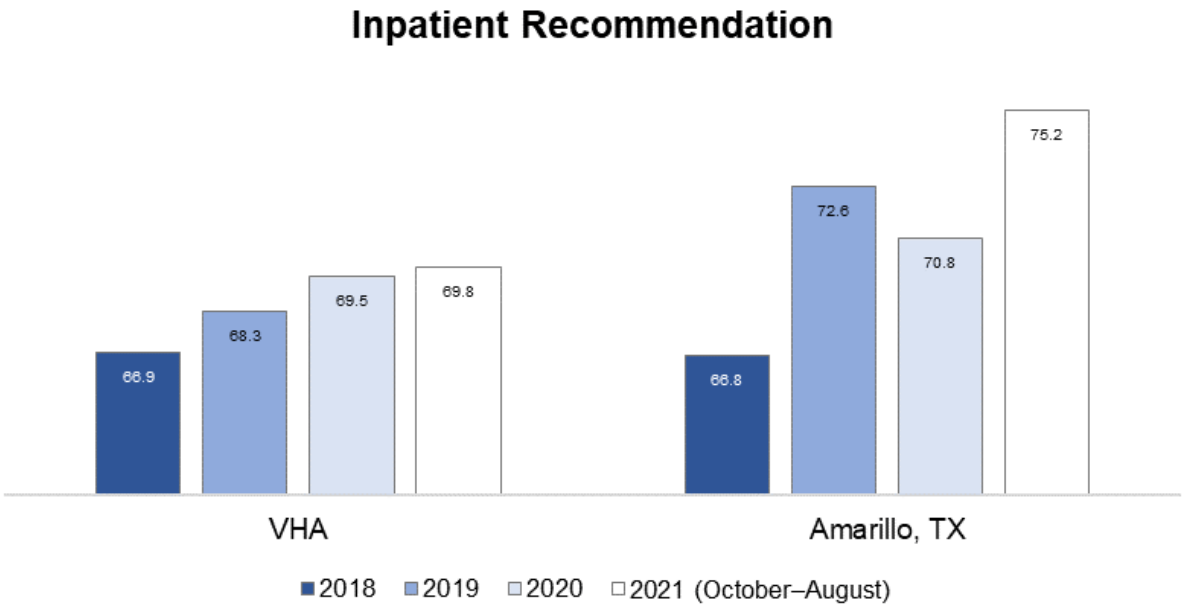

Figure 4. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 2021).

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

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

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

Patient satisfaction survey results in primary care generally reflected lower scores than the VHA averages beginning in FY 2019. The Director acknowledged that survey scores had significantly declined in FY 2020 and attributed the decrease to several factors including COVID-19 pandemic restrictions on face-to-face appointments, absence of a primary care service chief to provide guidance to staff, and patients' reluctance to use telehealth options for care. The Director attributed the notably improved FY 2021 score to increased availability of face-to-face encounters with clinicians and better use of telehealth appointments once veterans learned to access virtual health care.

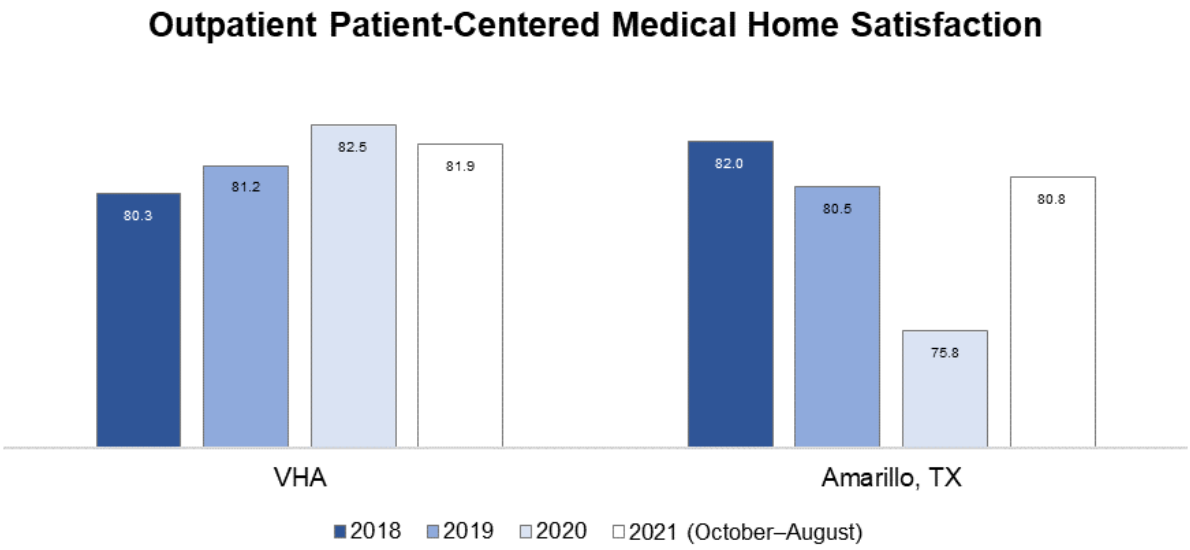

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 2021).

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

The healthcare system's specialty care satisfaction survey results highlighted opportunities for executive leaders to improve patient experiences. The Director attributed the lower scores to staffing challenges, lack of leadership at the service level to provide staff guidance, pandemic restrictions, and limited access to services. Expressing similar sentiments, the Chief of Staff identified staffing issues and the loss of specialty providers as factors contributing to the low scores. The Chief of Staff also reported an increased use of community care for specialty services and discussed developing a contract with physicians from Texas Tech Medical Center for clinical support in cardiology, general surgery, and podiatry.

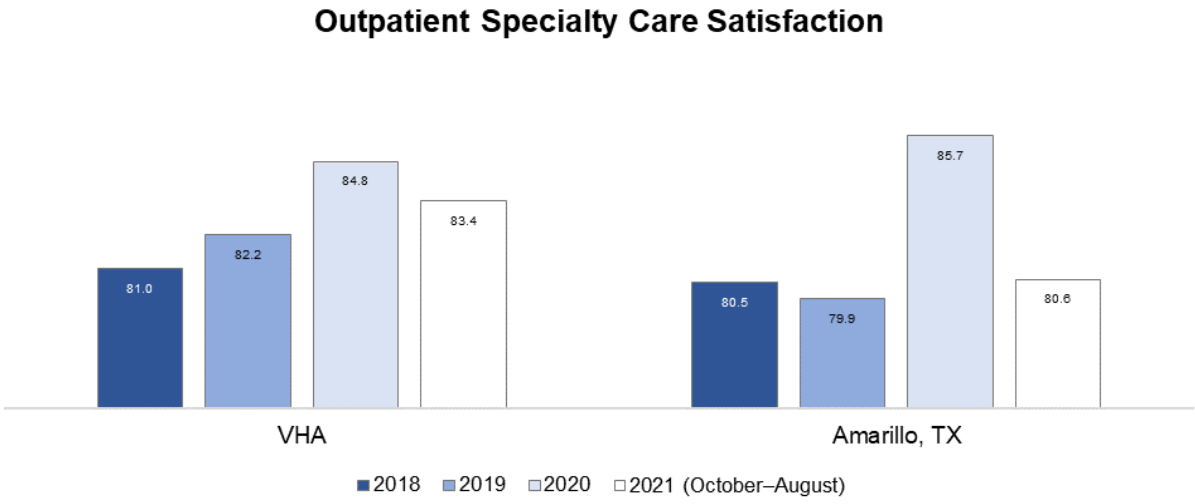

Figure 6. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 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

[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.

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 January 19, 2019 (the prior OIG CHIP site visit), through January 9, 2022.

Table 1. Summary of Selected Organizational Risk Factors (January 19, 2019, through January 9, 2022)

Factor	Number of Occurrences
Sentinel Events	2
Institutional Disclosures	4
Large-Scale Disclosures	0

Source: Amarillo VA Health Care Risk Manager, and Patient Safety Manager (received January 10, 2022).

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.[21] 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 the events as well as lose trust from patients and staff.[22]

The Director spoke knowledgeably about serious adverse event reporting and stated that leaders discussed adverse events at the Director's daily morning conference. The Director also described making institutional disclosure determinations in collaboration with the Chief of Staff, Risk Manager, and Patient Safety Manager. The Chief Quality Officer stated that all incidents were recorded in the Joint Patient Safety Reporting System and reviewed by all supervisors and

[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.

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

executive leadership team members. For events requiring urgent action, the Chief Quality Officer reported initiating immediate face-to-face discussions with executive leaders.

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG's inspection, the healthcare system's leadership team had worked together for about one month since the permanent appointment of the Chief of Staff. The Director, Nurse Executive, and Associate Director had been in their positions since 2020.

Healthcare system and executive leaders' survey results for employees' perceived ability to disclose a suspected violation without fear of reprisal were similar to or better than VHA averages. However, patient experience survey data showed opportunities for leaders to improve patient satisfaction in primary and specialty care clinics. The Director reported increased availability of face-to-face encounters and better use of telehealth appointments to improve patients' satisfaction with primary care. The Chief of Staff discussed increasing care in the community for specialty services and contracting with physicians from an outside medical center for clinical support in cardiology, general surgery, and podiatry to improve specialty care experiences. The OIG made no recommendations.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[23] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain accreditation from The Joint Commission.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[25]

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.[26] 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."[27] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[28]

Finally, the OIG assessed the healthcare system's culture of safety.[29] 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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[23] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[24] 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.)

[25] VHA Directive 1100.16.

[26] 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.

[27] VHA Directive 1190.

[28] VHA Directive 1190.

[29] 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.

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."[30] 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."[31]

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.[32] LIPs are granted clinical privileges for no more than two years and must be reprivileged prior to their expiration.[33]

VHA defines the Focused Professional Practice Evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[34] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[35] 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.[36]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[37] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the Chief of Staff. VHA also requires facilities to have credentialing

[30] 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.)
[31] VHA Handbook 1100.19.
[32] VHA Handbook 1100.19.
[33] VHA Handbook 1100.19.
[34] VHA Handbook 1100.19.
[35] VHA Handbook 1100.19.
[36] VHA Handbook 1100.19.
[37] VHA Directive 1100.20.

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

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

- Nine solo/few practitioners who underwent clinical privileging (four FPPEs and five OPPEs) in the previous 12 months[39]
- Seven LIPs who had an FPPE completed in the previous 12 months
- Twenty LIPs who were reprivileged in the previous 12 months

Medical Staff Privileging Findings and Recommendations

VHA requires FPPE criteria "to be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process and approved by the Director."[40] The OIG found that 3 of 11 practitioner profiles reviewed lacked evidence that service chiefs made LIPs aware of the evaluation criteria before initiating the FPPE process. (The OIG identified an additional provider whose FPPE was initiated about four months after the hire date and had not been completed at the time of the review.) When practitioners are not informed of the evaluation criteria, this could cause them to misunderstand FPPE expectations during this critical initial performance period.

The Chief Quality Officer reported there was a lack of oversight because the previous Chief of Staff discontinued the system's process of having the Assistant Chief, Quality Service Value, or designee review FPPE forms to ensure required elements were met.

[38] 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.

[39] 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). The OIG considers few practitioners as being two providers in the facility who are privileged in a particular specialty.

[40] VHA Handbook 1100.19.

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs define Focused Professional Practice Evaluation criteria in advance using objective criteria accepted by the practitioner.

Healthcare system concurred.

Target date for completion: July 31, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. Clinical Service Chiefs will utilize the Focused Professional Practice Evaluation (FPPE) Planning Sheet prior to initiating the FPPE process. The Ongoing Professional Practice Evaluation (OPPE)/FPPE Manager, Medical Staff Office, will assist the service chiefs and monitor compliance. All initial FPPE Planning Sheets will be presented at Credentials Committee and reported to Medical Executive Board. Compliance will be monitored until 90% compliance is achieved and sustained for six consecutive months. Compliance will be reported at Executive Health Care Committee through the governance structure.

VHA requires an executive committee of the medical staff to review and evaluate LIPs' privileging requests. Committee meeting minutes must indicate the materials reviewed and rationale for the conclusion. The committee then submits their recommendation to the director, who is the approving authority.[41] The OIG did not find evidence that the Medical Executive Board evaluated initial and reprivileging requests for all practitioner profiles reviewed. This function was performed by a professional standards board (known as the Medical Executive Council), which was not identified in the Medical Staff Bylaws as a committee authorized to make recommendations to the Director. Failure of the appropriate committee to document reviews and recommendations may result in incomplete evidence to support the Director's approval for granting or continuing clinical privileges. The Chief of Staff reported believing that staff complied with the VHA requirement because the Medical Executive Board and Medical Executive Council had similar members.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Medical Executive Board reviews and evaluates licensed independent practitioners' privileging requests and documents its review in the meeting minutes.

[41] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: March 31, 2023

Healthcare system response: The Chief of Staff evaluated this recommendation and did not identify any additional reasons for noncompliance. The Medical Executive Board now discusses the information from the Credentials Committee meeting and documents the discussion in the Medical Executive Board minutes. Compliance will be monitored until 90% compliance is achieved and sustained for six consecutive months. Compliance will be reported to Executive Health Care Committee through the governance structure.

VHA requires service chiefs to monitor the professional competency and performance of LIPs and that "results of the FPPE must be documented in the practitioner's provider profile."[42] While conducting this Medical Staff Privileging review, the OIG found that 3 of 4 solo/few practitioners' profiles did not have evidence that service chiefs completed the FPPEs. This resulted in solo/few practitioners providing care without a thorough review of their performance, which could adversely affect safe patient care. The Chief Quality Officer stated that for some solo/few practitioners, the system relied on the VISN 17 credentialing and privileging program manager to assign providers within the network to complete the evaluations and attributed the deficiency to a lack of follow-up by system staff to ensure the FPPEs were completed.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that service chiefs complete Focused Professional Practice Evaluations and document results in practitioners' profiles.

Healthcare system concurred.

Target date for completion: July 31, 2023

Healthcare system response: The Chief of Staff evaluated this recommendation and did not identify any additional reasons for noncompliance. The Medical Executive Board will add each practitioner's FPPE with anticipated closure date as an agenda item and discuss at each committee meeting until FPPE completion. Compliance will be monitored until 90% compliance is achieved and sustained for six consecutive months. Compliance will be reported to the Executive Health Care Committee through the governance structure. Adaptation of the standardized FPPE forms has been added to service chiefs' pay for performance for tracking and incentive purposes.

[42] VHA Handbook 1100.19.

The OIG also identified improvement opportunities with the healthcare system's credentialing and privileging process and VISN 17 leaders' lack of support to system staff's request for assistance in evaluating practitioners' performance. When the OIG addressed this concern with VISN leaders, the Deputy Quality Management Officer cited miscommunication between healthcare system and VISN credentialing and privileging staff. The Deputy Quality Management Officer also stated that VISN staff thought the list of solo/few practitioners they received was intended for information only and not as a request for assistance. The VISN 17 acting Deputy Chief Medical Officer stated that VISN staff had already taken actions to address and improve professional practice evaluations by implementing a SharePoint site for facility staff to upload FPPE and OPPE review requests, providing training on the process and timelines for requests, and developing a standard operating procedure that outlines inter-facility processes. It is imperative that system and VISN 17 leaders collaborate to ensure the system's credentialing and privileging process is strengthened even though the OIG did not make a recommendation.

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.[43] 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.

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.[44] 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 in emergencies and contribute to a safe healthcare environment.[45]

The OIG inspection team interviewed managers and examined relevant documents related to the healthcare system's environment of care.[46]

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[43] 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.)

[44] 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.

[45] 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.

[46] The OIG conducted the inspection virtually and did not perform a physical inspection at the healthcare system.

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."[47] 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."[48]

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.[49] The OIG determined 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."[50] The OIG assessed the healthcare system 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 managers and reviewed the electronic health records of 29 patients who were seen in the emergency department from December 31, 2020, through August 1, 2021.

Mental Health Findings and Recommendations

The OIG made no recommendations.

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

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

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

[50] 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 U.S. healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided three recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Chief of Staff. The intent is for this leader 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 define Focused Professional Practice Evaluation criteria in advance using objective criteria accepted by the practitioner. • The Medical Executive Board reviews and evaluates licensed independent practitioners' privileging requests and documents its review in the meeting minutes. • Service chiefs complete Focused Professional Practice Evaluations and document results in practitioners' profiles.
Environment of Care	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• None

Appendix B: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated healthcare system reporting to VISN 17.[1]

Table B.1. Profile for Amarillo VA Health Care System (504) (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	$243,691,478	$339,280,988	$352,818,091
Number of:			
• Unique patients	24,399	23,398	23,788
• Outpatient visits	262,040	221,611	252,469
• Unique employees§	1,008	1,073	1,160
Type and number of operating beds:			
• Community living center	120	120	120
• Medicine	30	30	30
• Surgery	14	14	14
Average daily census:			
• Community living center	149	104	62
• Medicine	15	14	18
• Surgery	2	1	1

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).*

[1] VHA medical facilities are classified according to a complexity model; a designation of "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 23, 2023

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Comprehensive Healthcare Inspection of the Amarillo VA Health Care System in Texas

To: Director, Office of Healthcare Inspections (54CH02)

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

Thank you for the opportunity to respond to the Comprehensive Healthcare Inspection of the Amarillo VA Health Care System in Texas. VA remains committed to honoring our Nation's Veterans by ensuring a safe environment to deliver exceptional health care. I agree with the action plans as they have been implemented from the Amarillo Leadership team.

I have reviewed and concur with the facility's response and will continue to oversee the progress of the actions.

(Original signed by:)

Wendell E. Jones, MD, MHA
VISN 17 Network Director

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: January 25, 2023

From: Director, Amarillo VA Health Care System (504/00)

Subj: Comprehensive Healthcare Inspection of the Amarillo VA Health Care System in Texas

To: Director, VA Heart of Texas Health Care Network (10N17)

1. Thank you for conducting the Comprehensive Healthcare Inspection (OIG) review during the week of January 10, 2022, at the Amarillo VA Health Care System.
2. The recommendations have been reviewed. Amarillo concurs with all recommendations.
3. A plan of action for each of the three recommendations is attached. The three plans of action have been carefully analyzed and will be implemented and monitored through satisfactory completion.
4. I have reviewed the document and concur with the response as submitted.

(Original signed by:)

Rodney S. Gonzalez, MD
Director

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