DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Comprehensive Healthcare Inspection of the West Texas VA Health Care System in Big Spring

CHIP REPORT | REPORT #22-00037-117 | MAY 11, 2023

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***Figure 1.*** *George H. O'Brien, Jr. VA Medical Center of the West Texas VA Health Care System in Big Spring.*

*Source: https://www.va.gov/west-texas-health-care/ (accessed February 15, 2022).*

# Abbreviations

| | |
|---|---|
| CHIP | Comprehensive Healthcare Inspection Program |
| FY | fiscal year |
| LIP | licensed independent practitioner |
| OIG | Office of Inspector General |
| OPPE | Ongoing Professional Practice Evaluation |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the outpatient settings of the West Texas VA Health Care System, which includes the George H. O'Brien, Jr. VA Medical Center in Big Spring, Texas; and clinics in Abilene, Fort Stockton, Midland/Odessa, and San Angelo, Texas; and Hobbs, 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 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)[1]

The OIG conducted an unannounced virtual inspection of the West Texas VA Health Care System during the week of January 10, 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 facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

[1] The OIG did not perform this review at the West Texas VA Health Care System because it did not have an emergency department or urgent care center.

## Inspection Results

The OIG noted an opportunity for improvement and issued one recommendation to the Chief of Staff in the Medical Staff Privileging review area. This result is detailed in the report section and summarized in appendix A on page 16.

### Conclusion

The OIG issued one recommendation 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 system. 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 systemic issue that may eventually interfere with the delivery of quality health care.

### VA Comments

The Veterans Integrated Service Network Director and Acting System Director agreed with the comprehensive healthcare inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, pages 18 and 19, and the response 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 recommendation until they are completed.

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for Healthcare Inspections

# Contents

# Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the outpatient settings of the West Texas 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 areas of clinical and administrative and 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)[5]

[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.

[5] The OIG did not perform this review at the West Texas VA Health Care System because it did not have an emergency department or urgent care center.

# Methodology

The West Texas VA Health Care System includes the George H. O'Brien, Jr. 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 May 10, 2019, through January 14, 2022, the last day of the unannounced multiday evaluation.[6] During the virtual 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.[7] 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 Acting Director's response to the report's recommendation appears within the Medical Staff Privileging review area. The OIG accepted the action plan that the leader 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.

[6] The OIG's last comprehensive healthcare inspection of the West Texas VA Health Care System occurred in May 2019. The Joint Commission performed ambulatory care, behavioral health care, and home care accreditation reviews in March 2021.

[7] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

# Results and Recommendations

## Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[8] 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."[9] 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.[10]

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

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Health Care System Director (Director); Chief of Staff; Associate Director, Patient Care Services; and Associate Director. The Chief of Staff and Associate Director, Patient Care Services 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 more than one and a half years, although two team members had been in their positions for more than three years. To help assess the executive leaders' engagement, the OIG interviewed the Director; Chief of Staff; Associate Director, Patient Care Services; and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

[8] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[9] Swensen, *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[10] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

## Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $256,767,992 had increased by almost 10 percent compared to the previous year's budget of $234,369,690.[11] The Associate Director stated that the increased funds had a great effect on operations, including allowing leaders to hire over 100 additional employees and increase recognition awards.

## Employee Satisfaction

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

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[14]

[11] Veterans Health Administration (VHA) Support Service Center.

[12] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center website.

[13] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center website.

[14] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders' All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

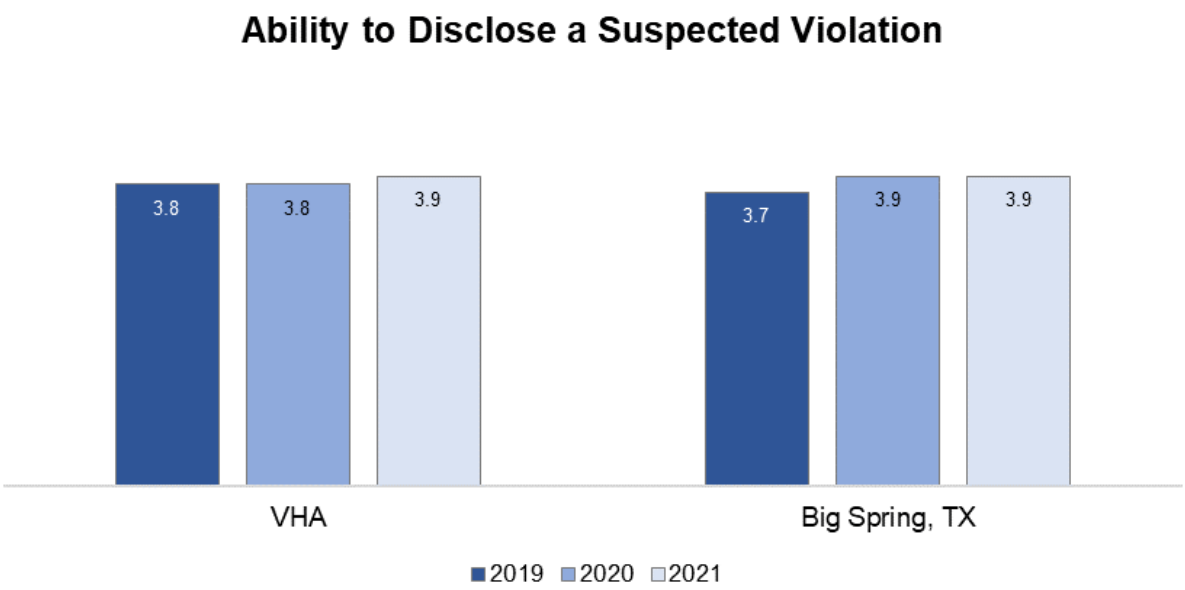


***Figure 2.*** *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

*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

Veterans Health Administration (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.[15]

VHA also collects Survey of Healthcare Experiences of Patients data from Patient-Centered Medical Home (primary care) and Specialty Care surveys.[16] The OIG reviewed responses to two relevant survey questions that reflect outpatient experiences with the healthcare system from October 1, 2017 (FY 2018), through August 31, 2021 (FY 2021). Figures 3 and 4 provide survey results for VHA and the healthcare system over time.[17]

[15] "Patient Experiences Survey Results," VHA Support Service Center website.

[16] "Patient Experiences Survey Results," VHA Support Service Center website.

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

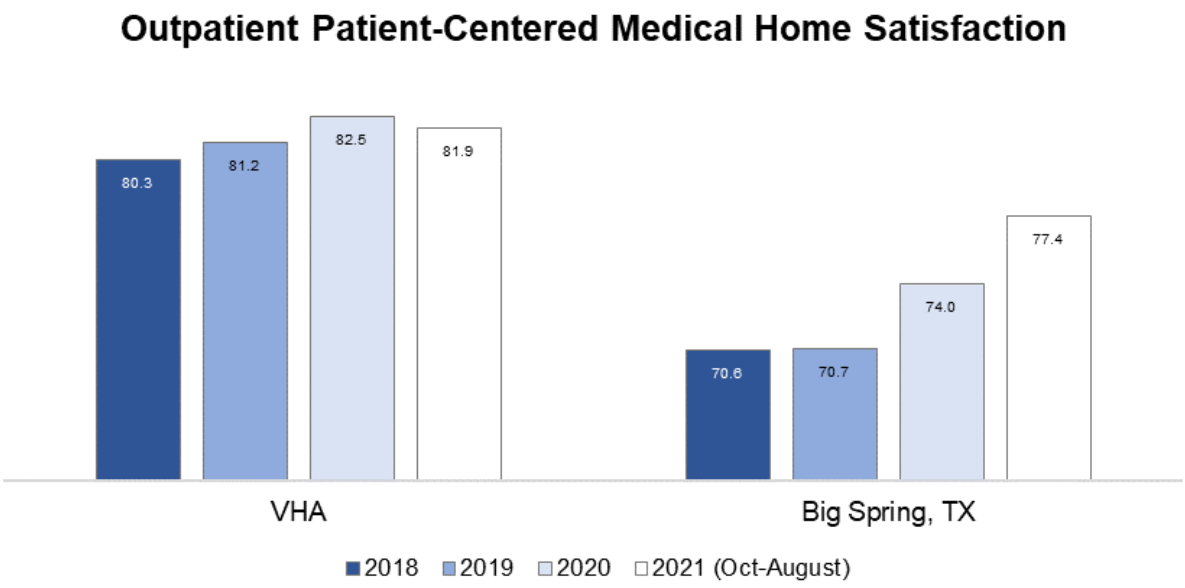


***Figure 3.*** *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

*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.*

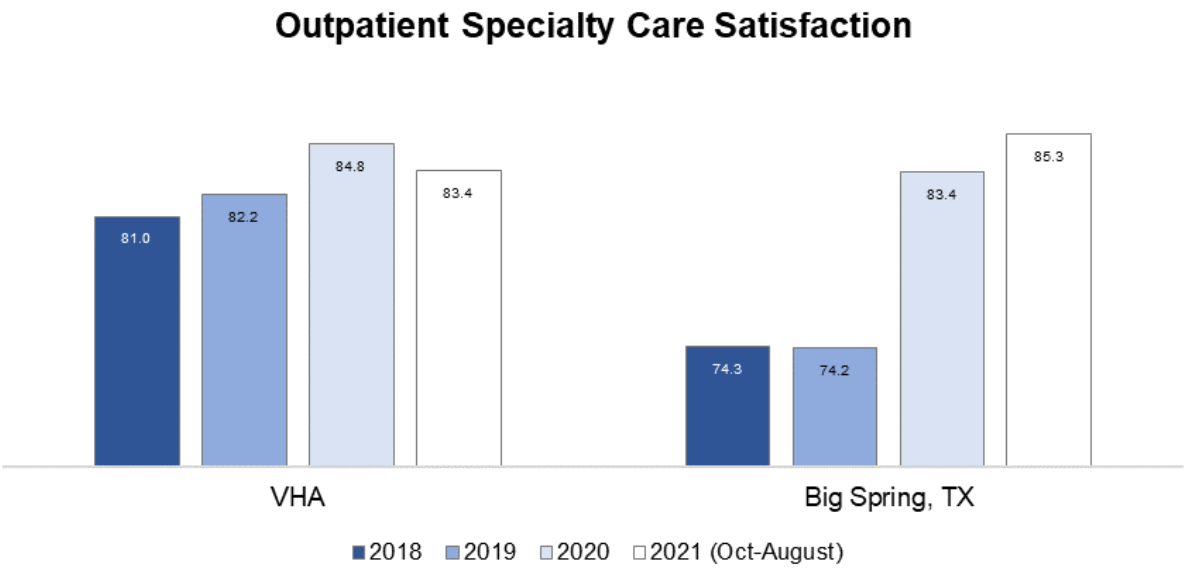


***Figure 4.*** *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

*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 patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[18] A sentinel event is an incident or condition that "results in death, permanent harm, or severe temporary harm and [when] intervention [is] required to sustain life."[19] 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."[20] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The OIG requested adverse patient safety events that occurred from May 10, 2019 (the prior OIG CHIP site visit), through January 10, 2022.

**Table 1. Adverse Patient Safety Events (May 10, 2019, through January 10, 2022)**

| Factor | Number of Occurrences |
|---|---|
| Sentinel Event | 1 |
| Institutional Disclosure | 0 |
| Large-Scale Disclosure | 0 |

*Source: West Texas VA Health Care System's Chief, Quality Management (received January 11, 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.[22] 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

[18] Frankel, *A Framework for Safe, Reliable, and Effective Care;* "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

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

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

[21] VHA Directive 1004.08.

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

events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[23]

The single sentinel event that occurred during the review period was a death due to a patient smoking while using home oxygen. Quality management staff explained that leaders did not conduct an institutional disclosure for the event because a home health agency discovered the patient, and the healthcare system did not learn about the event until months later. The Director reported that staff conducted a quality management review, the substance of which the OIG is not including in this report based on confidentiality protection under 38 U.S.C. § 5705. The Director also stated that leaders elevated monitoring of the home health agency contract to both the Clinical Contract Oversight Committee and Home Oxygen Group.

## Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

## Quality, Safety, and Value

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

To determine whether VHA facility staff 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 key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[27] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[28] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[29]

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

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

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

[25] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (This directive was rescinded and replaced by VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

[26] VHA Directive 1100.16.

[27] A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[28] VHA Directive 1190.

[29] VHA Directive 1190.

[30] A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organizations health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, accessed October 3, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

## Quality, Safety, and Value Findings and Recommendations

The OIG 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."[31] 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."[32]

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.[33] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[34]

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."[35] The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[36] 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.[37]

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.[38] 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

[31] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This handbook was rescinded and replaced by VHA Directive 1100.21, *Privileging*, March 2, 2023. The credentialing portion of this handbook was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[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 Handbook 1100.19.

[38] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[39]

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

- Two solo or few practitioners who underwent clinical privileging from December 2020 through December 2021[40]
- One LIP who had a Focused Professional Practice Evaluation completed from December 2020 through December 2021
- Eleven LIPs who were reprivileged from December 2020 through December 2021

## Medical Staff Privileging Findings and Recommendations

VHA requires that service chiefs' recommendation to continue current privileges be based, in part, on OPPE activities such as "direct observation, clinical discussions, and clinical pertinence reviews."[41] The OIG noted that for the two solo or few LIPs reprivileged, service chiefs could not demonstrate their recommendations to continue privileges were based on OPPE activities because they could not locate the OPPE forms. When service chiefs' evaluations lack adequate data to support recommendations, it may adversely affect the delivery of quality patient care. The Chief of Staff reported being unable to locate the missing OPPE forms due to frequent leadership and administrative staff turnover in the radiology and surgical specialty care services.

## Recommendation 1

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

[39] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[40] 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.

[41] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: The Chief of Staff evaluated and determined potential reasons for noncompliance of OPPE inclusion for service chiefs' recommendations to continue current privileges based on OPPE activities. In February 2022, the Credentialing Coordinator included statements in the Professional Standards Committee minutes reflecting OPPE reviews were discussed in recommendations to continue privileges. In February 2022, the VISN 17 Acting Chief Medical Officer established a process for the VISN 17 facilities to upload requests for external "Solo or few" OPPE reviews to [the] VISN 17 Credentialing and Privileging SharePoint for assignment by the VISN 17 Credentialing and Privileging Officer to an external provider to complete the review. The facility Chief of Staff or designee are notified when OPPEs are completed and can be forwarded to service chiefs for review and results discussed with providers. This process ensures that the required OPPE forms and chart reviews are available for service chiefs' evaluation before recommendation to renew privileges. The Credentialing Coordinator will conduct a monthly audit of completed OPPEs for the providers who were re-privileged during the audit period and report monthly to the Professional Standards Committee. Audits will be conducted until 90 percent compliance is maintained for 6 consecutive months.

Compliance Monitor: The numerator is the total number of providers with the required OPPE forms and chart reviews during the audit period. The denominator is the total number of providers re-privileged during the audit period.

## 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.[42] 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 staff at 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.[43] 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.[44]

During the OIG's review of the environment of care, the inspection team examined relevant documents and interviewed managers and staff. The OIG did not conduct a physical inspection because of the COVID-19 pandemic.

### Environment of Care Findings and Recommendations

The OIG made no recommendations.

[42] 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.)

[43] 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.

[44] 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.

## 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 and provided one recommendation on a systemic issue 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 finding illuminates an area of concern, and the recommendation may help guide improvement efforts. A recommendation summary 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 Chief of Staff. 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 | • None |
| Quality, Safety, and Value | • None |
| Medical Staff Privileging | • Service chiefs' recommendations to continue current privileges are based on Ongoing Professional Practice Evaluation activities. |
| Environment of Care | • None |

# Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 17.[1]

**Table B.1. Profile for West Texas VA Health Care System (519)**
**(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 | $140,358,215 | $234,369,690 | $256,767,992 |
| Number of: | | | |
| • Unique patients | 18,419 | 18,157 | 18,531 |
| • Outpatient visits | 169,185 | 157,669 | 186,504 |
| • Unique employees§ | 513 | 508 | 576 |
| Type and number of operating beds: | | | |
| • Community living center | 36 | 38 | 38 |
| • Domiciliary | 40 | 40 | 40 |
| Average daily census: | | | |
| • Community living center | 35 | 24 | 13 |
| • Domiciliary | 35 | 13 | 11 |

*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 "3" indicates a facility with "low volume, low risk patients, few or no 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: March 24, 2023

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

Subj: Comprehensive Healthcare Inspection of the West Texas VA Health Care System in Big Spring

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

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

Thank you for the opportunity to review and respond to the OIG Comprehensive Healthcare Inspection of the West Texas VA Health Care System.

I have reviewed and concur with the finding, recommendation and action plan submitted in the report.

*(Original signed by:)*

Wendell E. Jones, M.D.
VISN 17 Network Director

# Appendix D: Healthcare System Director Comments

## Department of Veterans Affairs Memorandum

Date: March 24, 2023

From: Director, West Texas VA Health Care System (519/00)

Subj: Comprehensive Healthcare Inspection of the West Texas VA Health Care System in Big Spring

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

Thank you for the opportunity to review the OIG Comprehensive Health Care Inspection Report provided for West Texas VA Health Care System in Big Spring, Texas.

I appreciate the professionalism and feedback provided to our staff during the onsite review conducted January 10 – January 14, 2022.

I have reviewed and concur with the finding, recommendation and action plans submitted as part of this report.

*(Original signed by:)*

Robert A. Hoff
Acting Director

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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