DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA North Texas Health Care System in Dallas

CHIP REPORT | REPORT #22-00038-125 | JUNE 6, 2023

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Figure 1. *Dallas VA Medical Center of the VA North Texas Health Care System in Dallas.*

Source: https://www.va.gov/north-texas-health-care.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
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 VA North Texas Health Care System, which includes the Dallas VA Medical Center, Garland VA Medical Center, Sam Rayburn Memorial Veterans Center (Bonham), and multiple outpatient clinics in Texas. 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 VA North Texas Health Care System from February 7 through 17, 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.

Inspection Results

The OIG noted opportunities for improvement and issued two recommendations to the Executive Director and Assistant Director Clinical Services in the Leadership and Organizational Risks and Mental Health areas of review. These results are detailed in the report sections and summarized in appendix A on page 20.

Conclusion

The OIG issued two recommendations for improvement to the Executive Director and Assistant Director Clinical Services. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care moving forward. The recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 23 and 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 VA North Texas 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)

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[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 (FY) 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The VA North Texas Health Care System includes the Dallas VA Medical Center, Garland VA Medical Center, Sam Rayburn Memorial Veterans Center (Bonham), and associated outpatient clinics in Texas. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from December 4, 2017, through February 17, 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 each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

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[5] The OIG's last comprehensive healthcare inspection of the VA North Texas Health Care System occurred in December 2017. The Joint Commission performed an opioid replacement clinic accreditation review in October 2020; hospital, behavioral health care, and home care accreditation reviews in May 2021; and laboratory accreditation reviews in April and September 2021.

[6] 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.[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

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 Executive Director (Director), Assistant Director Clinical Services, Assistant Director Patient Care Service, and Deputy Director. The Assistant Director Clinical Services and Assistant Director Patient Care Service 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 five months. The Assistant Director Clinical Services was the most tenured member of the team. The Director stated the VA Central Office recently changed the chief of staff and associate director for patient care services position titles to assistant director clinical services and assistant director patient care service, respectively. Furthermore, the Director reported the VA Central Office allocated the system a new Senior Executive Service deputy director position in August 2021. The Deputy

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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.

Director served in the associate director role for several years before assuming the newly created position.

To help assess the executive leaders' engagement, the OIG interviewed the Director, Deputy Director, Assistant Director Clinical Services, and Assistant Director Patient Care Service regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $1,653,430,026 had increased by approximately 5.5 percent compared to the previous year's budget of $1,567,260,853.[10] The Director reported a medical care budget increase of over $80 million, but Care in the Community costs of $400 million. Furthermore, the Director stated that leaders hired more nursing staff and used retention bonuses to better compensate nurses until the next salary increase was approved.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] 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.[12]

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

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

[12] 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 variation in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

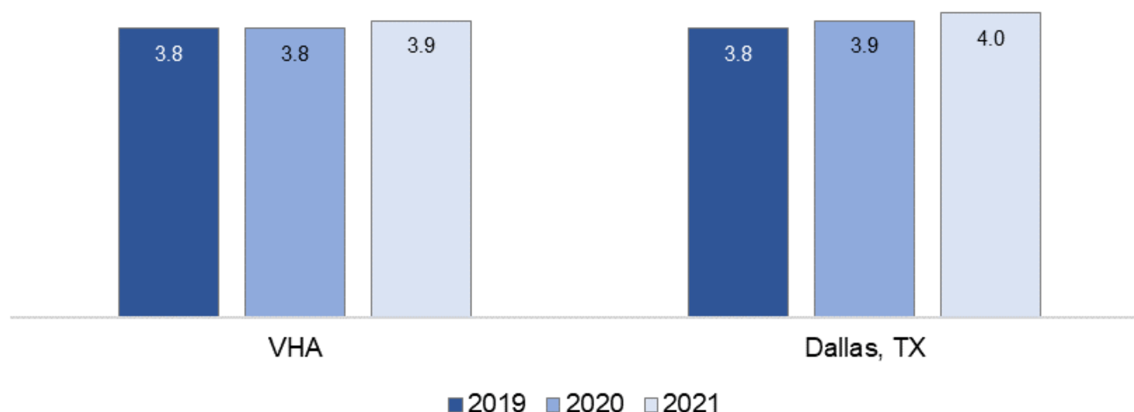

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed December 7, 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.[13]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from October 2017 (FY 2018) through August 2021 (FY 2021). Figures 3–5 provide survey scores for VHA and the healthcare system over time.[15]

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

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

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

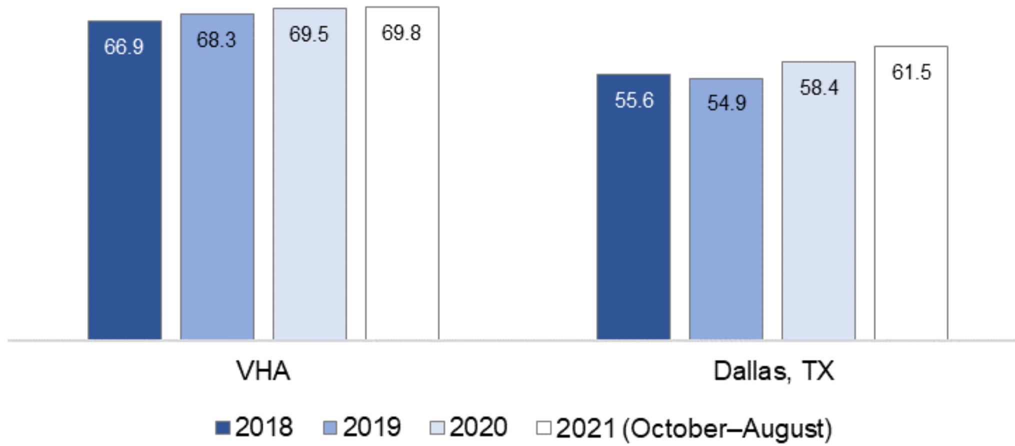

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

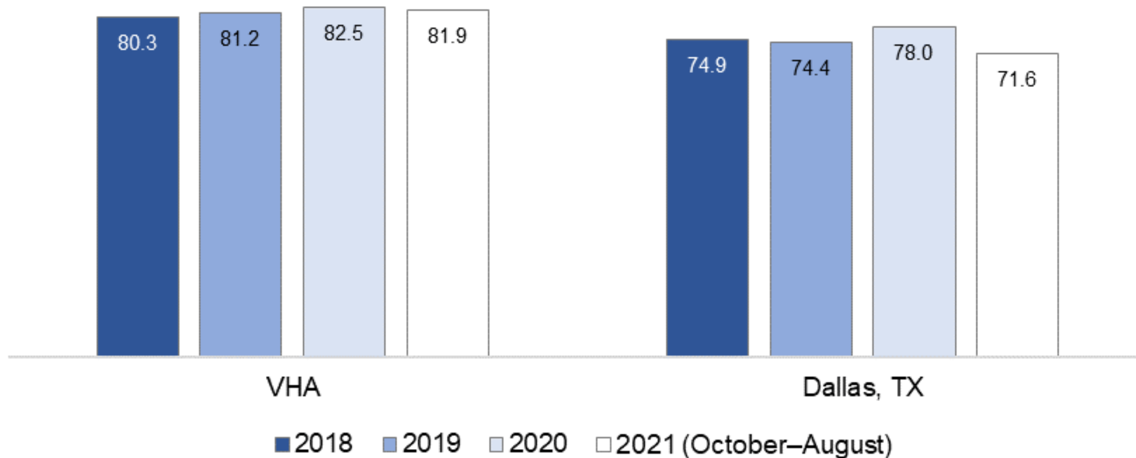

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

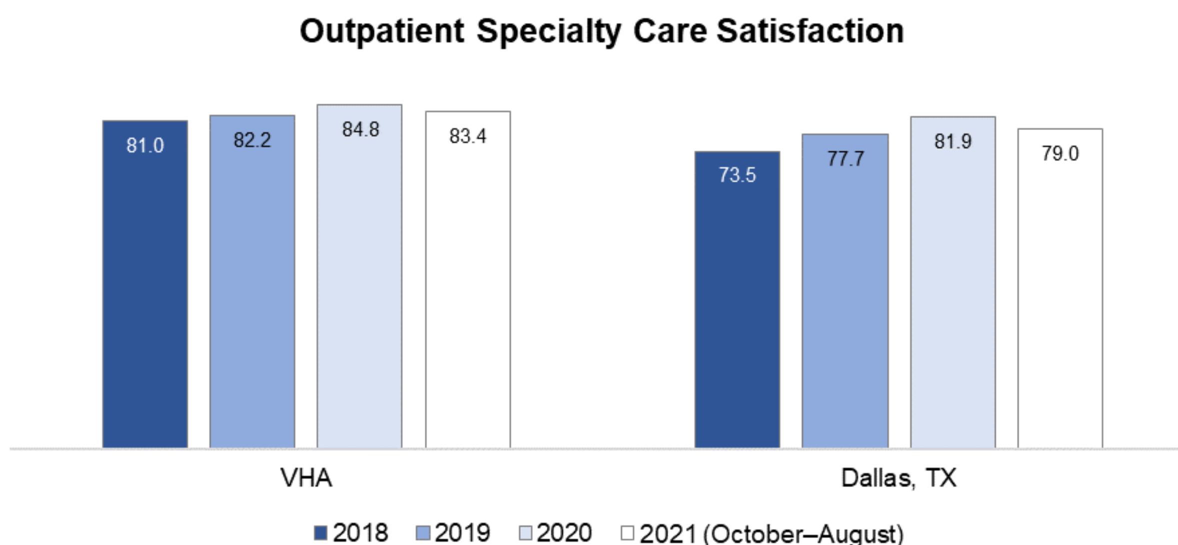

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.[16] 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."[17] 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."[18] 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."[19] To this end, VHA implemented

[16] 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/.

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

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

[19] VHA Directive 1004.08.

standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

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.[20] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[21]

The Director reported receiving patient safety information through morning meetings, emails, and verbal communication. Additionally, the Director stated that safety information emails were forwarded to the Chief, Quality Safety Value Service, and the respective service chiefs for follow-up. The Chief, Quality Safety Value Service, who also served as the Patient Safety Manager, reported identifying sentinel events by reviewing root cause analyses for major adverse events placed in WebSPOT.[22] Furthermore, the Chief shared that the Assistant and Deputy Assistant Directors Clinical Services determined if institutional disclosures were warranted. The Risk Management Coordinator reported being informed of sentinel events by the Chief, Quality Safety Value Service, and possible institutional disclosures by the leadership team, and that communication flowed well.

The OIG requested adverse patient safety events, which included sentinel events, institutional disclosures, and large-scale disclosures, that occurred from December 4, 2017 (the prior OIG CHIP site visit), through February 6, 2022. The OIG identified deficiencies related to institutional disclosures.

Leadership and Organizational Risks Findings and Recommendations

VHA considers the disclosure of harmful events "consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence" and requires leaders to inform or disclose to a patient or patient's personal representative when a sentinel event occurs and document the disclosure using the required note template.[23] The OIG reviewed the system-identified adverse patient safety events and institutional disclosures and found that leaders did not consistently

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

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

[22] WebSPOT is the software application used for reporting and documenting adverse events in VHA's patient safety information system. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

[23] VHA Directive 1004.08.

conduct and accurately document institutional disclosures.[24] Failure to disclose sentinel events can erode VA's core values and reduce patients' trust in the organization. The Chief, Quality Safety Value Service, reported that the lack of a solid oversight process due to previous turnover in the Quality Safety Value Service's chief and patient safety manager roles, along with COVID-19 pandemic demands, affected leaders' ability to meet the requirements.

Recommendation 1

1. The Executive Director evaluates and determines additional reasons for noncompliance and ensures leaders conduct and accurately document institutional disclosures for applicable sentinel events.

[24] The OIG found that staff documented institutional disclosures in routine nursing and provider notes versus the required template.

Healthcare system concurred.

Target date for completion: October 1, 2023

Healthcare system response: The Deputy Assistant Director, Clinical Services, who reports to the Assistant Director, Clinical Services, reviewed the recommendation and did not identify any additional reasons for noncompliance. The Deputy Assistant Director, Clinical Services created a checklist entitled “Sentinel Event and Adverse Event Screening Worksheet” to simplify, standardize and document the decision-making process when assessing potential sentinel/adverse events and to enhance collaboration between the Quality Safety Value Service and leadership of the medical staff in taking appropriate action. Use of the checklist began in February 2022, immediately following the OIG inspection. The checklist guided the categorization of an event as sentinel or an adverse patient safety event and generated appropriate recommendations for actions consistent with VHA requirements for clinical disclosure, institutional disclosure and/or sentinel event reporting and response. Routine weekly meetings were conducted to evaluate all events that met the definition of sentinel event for reporting or institutional disclosure. Attendance at the meetings included the Chief, Quality Safety Value Service, Patient Safety Manager(s), Peer Review Coordinator, and Risk Management Coordinator.

Once determinations had been made, the completed form with recommendations for action were sent to the Assistant Director and Deputy Assistant Director, Clinical Services for concurrence and final recommendations. Necessary institutional disclosures were conducted and documented by Assistant and Deputy Assistant Directors, Clinical Services and applicable service chiefs.

Six months of monitoring will occur to ensure 100 percent of institutional disclosures conducted were documented in a tracking spreadsheet maintained by the Risk Management Coordinator.

Institutional disclosures were reported monthly to the Executive Quality Safety Value Board that the Director chaired.

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."[25] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[27]

To determine whether staff at 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 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.[28] 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."[29] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[30]

Finally, the OIG assessed the healthcare system's culture of safety.[31] 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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[25] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

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

[27] VHA Directive 1100.16.

[28] 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.

[29] VHA Directive 1190.

[30] VHA Directive 1190.

[31] 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 November 7, 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."[32] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[33]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[34] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[35]

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."[36] The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[37] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[38]

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

[32] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Directive 1100.20.

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

The OIG interviewed key managers and selected and reviewed Focused and Ongoing Professional Practice Evaluations of LIPs, including a facility-reported solo practitioner.[41]

Medical Staff Privileging Findings and Recommendations

The OIG issued no recommendations.

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[40] 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.

[41] 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.[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 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 during emergencies and contribute to a safe healthcare environment.[44]

The OIG evaluated whether staff completed environment of care inspections and tracked issues until they were resolved. The OIG also evaluated staff's implementation of the Rapid Naloxone Initiative.

Environment of Care Findings and Recommendations

The OIG made no recommendations.

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[42] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded and replaced this directive 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 March 22, 2022, 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.

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

Suicide prevention remains the top clinical 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.”[45] 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.”[46]

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 Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[47] 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.”[48] 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 facility staff complied with selected requirements for suicide risk evaluation, the OIG reviewed the electronic health records of 50 randomly selected patients who were seen in the emergency department or urgent care center from December 31, 2020, through August 1, 2021.

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

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

[47] 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.)

[48] 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. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions,” October 1, 2021.)

Mental Health Findings and Recommendations

VHA requires medical center staff to attempt weekly follow-up until care is established for patients "determined to be at intermediate or high acute or chronic risk of suicide via the VA Comprehensive Suicide Risk Evaluation and are deemed to be safe to discharge to home" from the emergency department.[49] The OIG found that for two of seven applicable patients, staff did not attempt follow-up within seven days of discharge from the emergency department.

Although the first patient was identified as intermediate acute and chronic risk for suicide at discharge, mental health staff initiated follow-up 15 calendar days later. The second patient was discharged from the emergency department and determined to be low acute and intermediate chronic risk for suicide. The mental health team's initial post-discharge contact and telehealth visit with the patient occurred approximately 70 days later.

Lack of follow-up may lead to missed support and mitigation of harm. The Supervisor, Consultant Liaison reported that mental health staff placed a referral note in the patient's chart to initiate appropriate follow-up care. In addition, the Supervisor, Consultant Liaison reported that members of the mental health team had difficulty reaching some patients by phone after they left the facility, which affected staff's ability to provide follow-up care.

Recommendation 2

2. The Assistant Director Clinical Services evaluates and determines any additional reasons for noncompliance and ensures mental health staff attempt weekly follow-up until care is established for patients discharged from the emergency department who are at intermediate or high acute or chronic risk of suicide.

[49] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions."

Healthcare system concurred.

Target date for completion: October 1, 2023

Healthcare system response: The Interim Associate Chief of Staff for Mental Health reviewed the recommendation and did not identify any additional reasons for noncompliance. A Suicide Prevention Coordinator (SPC) has been designated to follow up with all Veterans in the identified subgroup within seven days of discharge from the emergency department to ensure weekly contact until care is established with their assigned Mental Health Team. The SPC will review the Suicide Prevention Detail Report dashboard at least weekly to identify patients discharged from the emergency department that are at intermediate or high acute or chronic risk for suicide. The SPC will attempt weekly phone calls to the applicable patients until follow-up care is established. During these phone contacts, the SPC will assess for suicidality, address immediate needs, and provide any needed information and/or emotional support. The SPC will document the patient contacts in a Suicide Risk Management Follow-Up note in the electronic medical record.

The SPC will use a tracking spreadsheet to document the weekly phone calls. The information documented includes the date of each attempt to reach the Veteran, the date the Veteran engaged in health care, and the reason the case was closed. If the designated SPC is on leave, another SPC will be identified to cover the phone calls to ensure timely completion of calls and continuity of care.

Compliance is tracked using the denominator "total number of patients discharged from the emergency room that require weekly follow up phone contact until seen by a mental health provider." The numerator is the number of patients with documented weekly phone contact attempts. The SPC will track and monitor compliance with phone call attempts until 90 percent or higher is achieved, then for six consecutive months to demonstrate sustainment. The SPC will report the phone call attempt compliance rate monthly to the Mental Health Performance Measures meeting, which will then be reported to the Executive Committee of the Medical Staff chaired by the Assistant Director, Clinical Services. The Executive Committee of the Medical Staff will report compliance to the Executive Quality, Safety & Value Board chaired by the Executive Medical Center Director.

To date, the SPC has provided weekly contacts for 122 Veterans since November 9, 2021.

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 review of five clinical and administrative areas and provided two 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 two OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Executive Director and Assistant Director Clinical Services. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• Leaders conduct and accurately document institutional disclosures for applicable sentinel events.
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Mental health staff attempt weekly follow-up until care is established for patients discharged from the emergency department who are at intermediate or high acute or chronic risk of suicide.

Appendix B: Healthcare System Profile

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

Table B.1. Profile for VA North Texas Health Care System (549) (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	$1,249,822,398	$1,567,260,853	$1,653,430,026
Number of: • Unique patients	134,132	136,692	143,012
• Outpatient visits	1,562,789	1,412,282	1,547,847
• Unique employees§	5,300	5,523	5,730
Type and number of operating beds: • Community living center	235	235	235
• Domiciliary	272	272	264
• Medicine	157	170	157
• Mental health	35	35	35
• Residential rehabilitation	19	19	19
• Spinal cord	30	30	26
• Surgery	57	57	57
Average daily census: • Community living center	185	179	150
• Domiciliary	192	7134	84
• Medicine	126	128	148
• Mental health	22	19	13
• Residential rehabilitation	11	15	8
• Spinal cord	14	14	12

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

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Average daily census, cont.: • Surgery	20	18	16

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: March 28, 2023

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

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

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

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

1. Thank you for the opportunity to review the draft report of recommendations from the OIG Comprehensive Healthcare Inspection Program Review conducted at VA North Texas Health Care System. We have reviewed the report and concur with the recommendations. Action plans for each finding have been identified and are in various stages of implementation.
2. We would like to extend our appreciation to the entire Office of Inspector General Team who was consultative, professional, and provided excellent feedback to our staff. We appreciate the thorough review and the opportunity to further improve the quality care we provide to our Veterans every day.

(Original signed by:)

Wendell Jones, MD, MBA

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 27, 2023

From: Executive Medical Center Director, VA North Texas Health Care System (549/00)

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

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

1. Thank you for the opportunity to review the draft report of recommendations from the OIG Comprehensive Healthcare Inspection Program Review conducted at VA North Texas Health Care System. We have reviewed the report and concur with the recommendations. Action plans for each finding have been identified and are in various stages of implementation.
2. We would like to extend our appreciation to the entire Office of Inspector General Team who was consultative, professional, and provided excellent feedback to our staff. We appreciate the thorough review and the opportunity to further improve the quality care we provide our veterans every day.

(Original signed by:)

Jason Cave, JD, SES

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