DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the South Texas Veterans Health Care System in San Antonio

CHIP REPORT | REPORT #22-00040-115 | MAY 17, 2023

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Figure 1. *Audie L. Murphy Memorial Veterans' Hospital of the South Texas Veterans Health Care System in San Antonio.*

Source: https://www.va.gov/south-texas-health-care/locations/ (accessed October 20, 2022).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the South Texas Veterans Health Care System, which includes the Audie L. Murphy Memorial Veterans' Hospital in San Antonio, the Kerrville VA Medical Center, 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 South Texas Veterans Health Care System during the week of February 7, 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 three recommendations to the Director and Chief of Staff in the following areas of review: Leadership and Organizational Risks, Medical Staff Privileging, and Mental Health. These results are detailed throughout the report and summarized in appendix A on page 22.

Conclusion

The OIG issued three recommendations for improvement to the Director and Chief of Staff. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 25–26, 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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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 inpatient and outpatient settings of the South Texas Veterans 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 South Texas Veterans Health Care System includes the Audie L. Murphy Memorial Veterans' Hospital in San Antonio, Kerrville VA Medical Center, and associated outpatient clinics in Texas. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from May 22, 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 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 Executive 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.

[5] The OIG's last comprehensive healthcare inspection of the South Texas Veterans Health Care System occurred in May 2017. The Joint Commission (TJC) performed hospital, behavioral health care, and home care accreditation reviews July 31 to August 4, 2017, and hospital, behavioral health care and human services, and home care accreditation reviews in May 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 leadership team consisted of the Director; Deputy Director; Assistant Director, Chief Experience Officer; Associate Director; Assistant Director, Facilities; Associate Director for Patient Care Services (ADPCS); Chief Quality Officer; and Chief of Staff. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

The Director reported receiving approval for a new deputy director position, with the recruited staff member scheduled to start in March 2022. At the time of the OIG inspection, the executive team had worked together since November 2021. The Chief of Staff, the longest tenured leader, had been in the role since 2010, but an acting staff member covered the position after the leader was temporarily detailed to the VHA Office of Community Care in June 2021. To help assess the executive leaders' engagement, the OIG interviewed the Director, Acting Chief of Staff,

[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.

ADPCS, and Associate Director 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 $1,218,342,521 had increased by approximately 12 percent compared to the previous year's budget of $1,089,396,467.[10] The Director stated the current budget was adequate, but the system was one of the most rapidly growing in the nation.

The Associate Director, Acting Chief of Staff, and ADPCS shared concerns related to staff onboarding delays caused by human resources modernization efforts. The Associate Director stated that the system returned approximately $30,000,000 in budget allocations to the VISN due to delays in onboarding new employees. The Associate Director further explained that leaders partnered with the VISN to improve hiring timeliness.

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.[12] 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 (see figure 2).[13]

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

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

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

[13] 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).

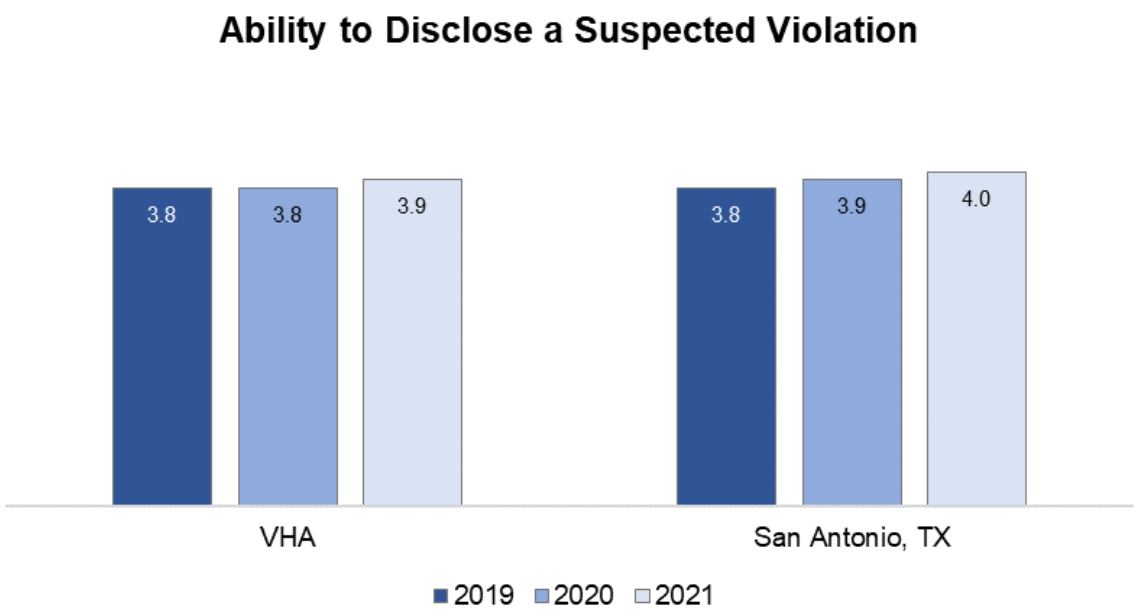

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from October 1, 2017 (FY 2018), through August 31, 2021 (FY 2021). Figures 3–5 provide survey results for VHA and the healthcare system over time.[16]

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

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

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

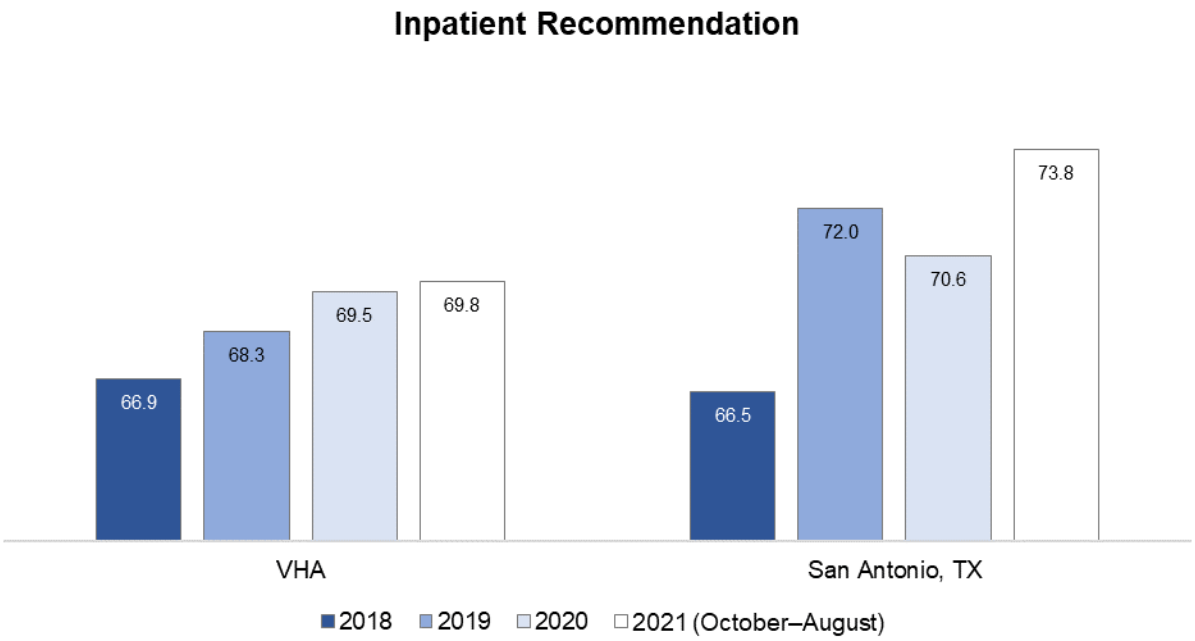

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

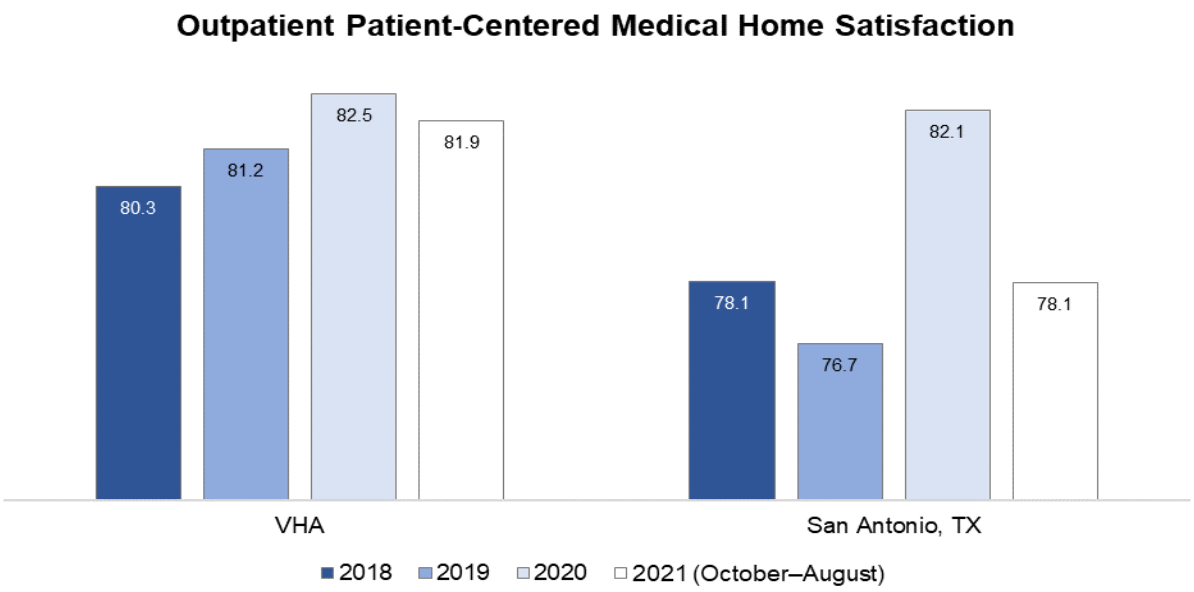

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

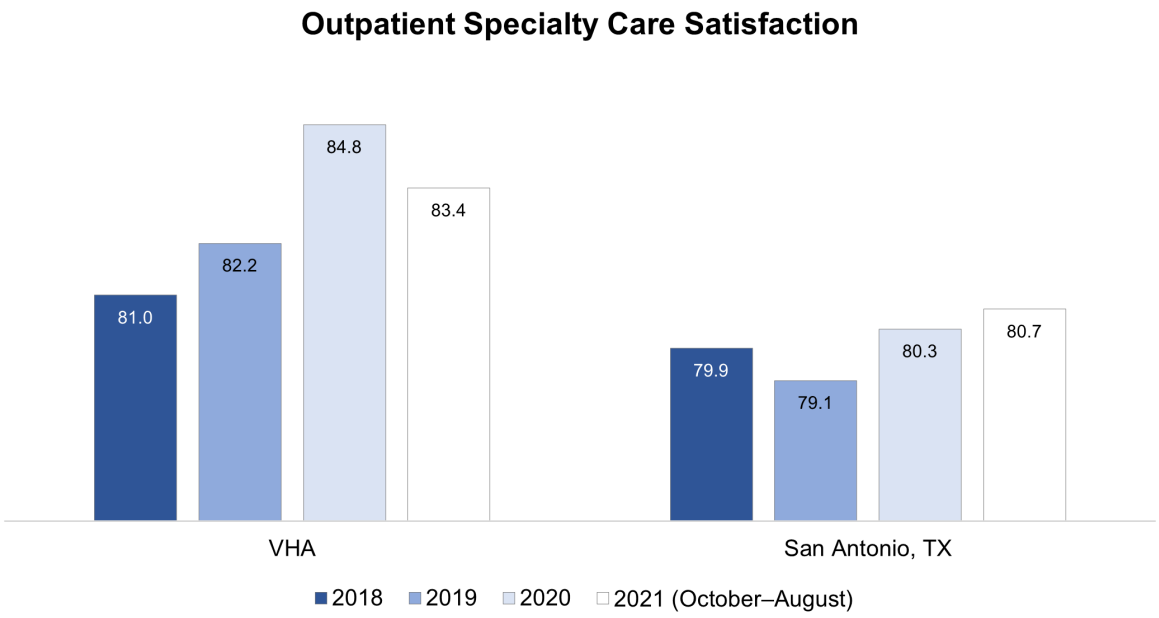

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.[17] 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."[18] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[19] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been

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

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

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

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.

The OIG requested adverse patient safety events that occurred from May 22, 2017 (the prior OIG CHIP site visit), to February 7, 2022.

Table 1. Adverse Patient Safety Events (May 22, 2017, to February 7, 2022)

Factor	Number of Occurrences
Sentinel Events	18
Institutional Disclosures	14
Large-Scale Disclosures	0

Source: South Texas Veterans Health Care System's Chief of Patient Safety and Risk Management and the Risk Manager.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's (TJC's) standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[21] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[22]

The Acting Chief of Staff and ADPCS reported participating in the institutional disclosure process. The Acting Chief of Staff described a collaborative process with the Chief Quality Officer and Risk Manager to determine when an institutional disclosure was warranted and explained meeting with the patient, family member, or both to discuss the event. The Director spoke knowledgably about the adverse event reporting process and ensuring leaders' awareness through huddles, patient safety reports, anonymous email messages, and direct communications

[20] VHA Directive 1004.08.

[21] TJC, *Standards Manual*, E-dition, July 1, 2022.

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

with Quality, Safety, and Value staff. The Director discussed conducting the peer review process, initiating root cause analyses, and reporting sentinel events to TJC.[23]

The OIG reviewed the 18 sentinel events and 14 institutional disclosures reported by healthcare system staff and identified a vulnerability with the institutional disclosure process.

Leadership and Organizational Risks Findings and Recommendations

VHA requires leaders to conduct an institutional disclosure when an adverse event causes or may cause the patient's death or serious injury.[24] The OIG determined that leaders did not always complete institutional disclosures for events that may have contributed to the patient's death. Failure to disclose the events may reduce patients' trust in the organization.

The Risk Manager reported that institutional disclosure decisions included determining whether each adverse event was major or minor, and when asked the difference between clinical and institutional disclosures, stated staff conducted clinical disclosures for minor adverse events. The Chief of Patient Safety and Risk Management said that executive leaders decided whether to conduct an institutional disclosure.

Recommendation 1

1. The Director determines the reasons for noncompliance and ensures leaders evaluate adverse events and conduct institutional disclosures when criteria are met.

[23] 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. A root cause analysis is a focused review to identify the actual system- and process-related contributing factors of the event. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011. (This handbook was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

[24] VHA Directive 1004.08.

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response:

Effective March 31, 2023, the Chief of Patient Safety and Risk Management and Risk Manager revised their current adverse events/sentinel events spreadsheet to add the following elements not previously tracked:

a.) Date Facility Leadership was notified of the event and

b.) Response of Leadership of the event (Concurrence/Nonconcurrence)

In addition to the existing process, the following actions were added:

1) The Risk Manager will receive notification of potential adverse events/sentinel events from the Chief of Patient Safety and Risk Management and/or other sources. The Patient Safety Manager/Risk Manager will review the potential event to determine if this meets criteria for an adverse event/sentinel event to make a recommendation to Chief of Staff (COS)/Associate Director for Patient Care Services (ADPCS)/Executive Leadership Team (ELT) and receive a final adjudication from COS/ADPCS/ELT.

2) Risk Manager will be responsible for documenting the ELT's adjudication, and the monitoring of the spreadsheet monthly.

3) The Chief of Patient Safety and Risk Management will audit compliance with adverse events/sentinel events spreadsheet including documentation of completed disclosure(s) monthly and will report progress to the Quality Safety and Value (QSV) Board quarterly until compliance is sustained at 90% for six consecutive months:

• The numerator equals the total number of adjudicated events in which institutional disclosure occurred from Veterans' electronic health record from April 1, 2023, through September 30, 2023.

• The denominator equals the total number of adjudicated events by COS/ADPCS/ELT from April 1, 2023, through September 30, 2023.

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 staff at its facilities to implement programs to monitor the quality of patient care and performance improvement activities and maintain TJC accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from TJC).[27]

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.[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. (This directive was rescinded and replaced by VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

[27] VHA Directive 1100.16.

[28] 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 October 3, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospitalusersguide.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. (This handbook was rescinded and replaced by VHA Directive 1100.21, *Privileging*, March 2, 2023. The credentialing portion of this handbook was previously replaced by 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 the privileging folders of 35 medical staff members who had a Focused Professional Practice Evaluation or Ongoing Professional Practice Evaluation completed from January 1 through December 31, 2021.

Medical Staff Privileging Findings and Recommendations

VHA requires that, at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific Ongoing Professional Practice Evaluation data when recommending the continuation of LIPs' privileges to an executive committee of the medical staff.[41] For the selected LIPs reprivileged from January 1 through December 31, 2021, the OIG found that some Ongoing Professional Practice Evaluations did not include service-specific data. This resulted in incomplete data to support service chiefs' recommendations to continue the LIPs' clinical privileges. The acting Deputy Chief of Staff reported that another similarly privileged provider evaluated LIPs by reviewing patient records related to their specialty and believed this met the requirement.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs consider service-specific Ongoing Professional Practice Evaluation data when recommending licensed independent practitioners' continued privileges.

[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 Handbook 1100.19. This system's executive committee of the medical staff was the Clinical Executive Board.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response:

The Professional Standards Board (PSB), a subcommittee of the Clinical Executive Board, approved National Clinical Indicators on 10/5/2021, effective for the Ongoing Professional Practice Evaluation (OPPE) cycles 10/1/2021 – 3/31/2022 and 4/1/2022 – 9/30/2022. These clinical indicators are service-specific and address the Patient Care and Medical and Clinical Knowledge domains on our Professional Practice Evaluations. In addition to the National Clinical Indicators, the PSB also approved on 10/5/2021, service-specific clinical indicators that address Systems-based Practice, Practice-based Learning and Improvement, Professionalism, and Interpersonal and Communication Skills for all specialties. The chart reviews and OPPEs for the health care system are coordinated by the OPPE and Focused Professional Practice Evaluation (FPPE) Nurses who works for the Chief of Staff. All the OPPEs are reviewed by the Service Chiefs prior to reprivileging. Medical Staff Office will perform 100% audit of Licensed Independent Practitioners (LIP) who are reprivileged until 90% compliance is sustained for 6 consecutive months. Outcomes of the action items will be reported monthly through the Internal Readiness Committee to the Quality Safety Value Board (QSVB).

An audit form will be developed to encompass the following fields:

a) PSB Date

b) Name of Reprivileged Licensed Independent Practitioner (LIP)

c) Dates of most recent OPPE reviewed by Service Chief for reprivileging decision

d) Clinical Indicators on most recent OPPE that are specialty-specific (list)

e) Compliance with requirement that OPPE includes specialty-specific indicators

* The numerator will be the total number of OPPEs for LIPs presented at Professional Standards Board (PSB) that utilized service-specific data.

* The Denominator will be the total number of OPPEs for LIPs completed and presented at PSB for reprivileging.

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

The OIG determined whether staff completed environment of care inspections and tracked issues until they were resolved. Additionally, the OIG evaluated the naloxone program.

Environment of Care Findings and Recommendations

The acting Nurse Manager explained that in February 2022, staff implemented panic alarm testing with police response times after self-identifying this as an opportunity for improvement. Although staff completed mental health environment of care inspections in July 2021 and tracked the issues as required, the OIG noted that several issues had not been resolved by January 2022, and there were no indications of actions taken to correct them.

The OIG made no recommendations.

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[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 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 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."[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 the emergency department and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 49 randomly selected patients who were seen in the emergency department from December 31, 2020, through August 1, 2021.

[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 patients identified as intermediate, high-acute, or chronic risk-for-suicide, and who are deemed safe to be discharged home from the emergency department to receive, at a minimum, weekly in-person or telephone contact attempts until the patient has attended one outpatient mental health appointment or has been admitted to an inpatient or residential unit.[49]

Of the selected patients, four were discharged from the emergency department with a positive suicide screen; however, two patients did not receive follow-up within seven days, as required. Lack of timely follow-up care may lead to missed opportunities for staff to provide support, continue risk mitigation, ensure smooth care transition, and monitor continuity of care. The Chief of Inpatient Psychiatry Service reported believing staff met the requirement because the patients were previously established with mental health services.

Recommendation 3

3. The Director evaluates and determines any additional reasons for noncompliance and ensures staff conduct follow-up within one week for intermediate, high-acute, or chronic risk-for-suicide patients who were discharged home from the emergency department.

[49] 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."

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response:

In January 2022, an outpatient mental health Registered Nurse (RN) was assigned primary responsibility to conduct follow-up calls within one week of a Veteran identified as intermediate, high-acute, or chronic risk-for-suicide who are safely discharged home from the emergency department (ED). The RN completed training through her Nurse Manager utilizing Rocky Mountain Mental Illness Research Education and Clinical Center for suicide prevention Safety Planning in the Emergency Department (SPED) material prior to the assignment. In March 2023, a second outpatient mental health RN was assigned secondary responsibility and training was provided by the primary RN currently conducting the follow-up calls. The RNs identify SPED follow-up eligible cases via the VHA Support Service Center (VSSC) SPED Suicide Prevention Detail Report and make follow-up calls the same business day an eligible Veteran populates on the SPED Detail Report. Additionally, they make follow-up calls every week thereafter until engaged in mental healthcare, declined further outreach, or until at least four consecutive unsuccessful weekly follow-up attempts are made to reach the Veteran including an outreach letter. The RNs utilize the Suicide Risk Management (SRM) national note template to document chart audits, outreach efforts, mental health engagement, and care coordination. Utilization of the SRM note and its embedded Health Factors facilitate follow-up call monitoring and tracking within SPED Detail Report for all users across the enterprise. The Quality Management (QM) Clinician for suicide prevention will review and analyze all SPED-eligible cases via the VSSC SPED Detail Report monthly until 90% compliance is sustained for 6 consecutive months. Audit data will be reported to the outpatient mental health Nurse Manager, the facility Suicide Prevention Director, the Emergency Department Suicide Prevention Workgroup, and thru the Internal Readiness Committee to the Quality and Safety Value Board monthly.

• The numerator will be the number of SPED-eligible follow-up calls made within one week of discharge from the ED.

• The denominator will be the number of SPED-eligible cases that require a follow-up call within one week of discharge from the ED.

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 key 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 Director and Chief of Staff. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• Leaders evaluate adverse events and conduct institutional disclosures when criteria are met.
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs consider service-specific Ongoing Professional Practice Evaluation data when recommending licensed independent practitioners' continued privileges.
Environment of Care	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Staff conduct follow-up within one week for intermediate, high-acute, or chronic risk-for-suicide patients who were discharged home from the emergency department.

Appendix B: Healthcare System Profile

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

Table B.1. Profile for South Texas Veterans Health Care System (671) (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	$894,828,880	$1,089,396,467	$1,218,342,521
Number of:			
• Unique patients	100,043	101,659	114,166
• Outpatient visits	1,257,804	1,202,601	1,412,937
• Unique employees§	3,769	4,007	4,138
Type and number of operating beds:			
• Community living center	185	185	185
• Domiciliary	66	66	66
• Medicine	101	101	101
• Mental health	33	33	33
• Rehabilitation medicine	22	22	22
• Spinal cord	30	30	30
• Surgery	46	46	46
Average daily census:			
• Community living center	129	88	57
• Domiciliary	60	31	17
• Medicine	70	85	95
• Mental health	22	16	14
• Rehabilitation medicine	15	12	16
• Spinal cord	16	12	10

[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	16	12	13

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: April 13, 2023

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

Subj: Comprehensive Healthcare Inspection of the South Texas Veterans Health Care System in San Antonio

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

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 South 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 29, 2023

From: Executive Director, South Texas Veterans Health Care System (671/00)

Subj: Comprehensive Healthcare Inspection of the South Texas Veterans Health Care System in San Antonio

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 February 7, 2022, at the South Texas Veterans Health Care System.
2. The recommendations have been reviewed. South Texas 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:)

Julianne Flynn, M.D.
Executive Director

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