DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the New Mexico VA Health Care System in Albuquerque

CHIP REPORT | REPORT #22-00046-126 | JUNE 7, 2023

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Figure 1. *Raymond G. Murphy VA Medical Center of the New Mexico VA Health Care System in Albuquerque.*

Source: https://www.va.gov/new-mexico-health-care/.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
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 New Mexico VA Health Care System, which includes the Raymond G. Murphy VA Medical Center (Albuquerque) and multiple outpatient clinics in Colorado and New Mexico. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

The OIG conducted an unannounced inspection of the New Mexico VA Health Care System during the week of February 14, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration 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 seven recommendations to the Executive Director; Chief of Staff; Associate Director, Patient Care Services; Associate Director; and Assistant Director in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; and Environment of Care. These results are detailed throughout the report and summarized in appendix A on page 24.

Conclusion

The OIG issued seven recommendations for improvement to the Executive Director; Chief of Staff; Associate Director, Patient Care Services; Associate Director; and Assistant Director. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for 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 27–28, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 2 and 6 closed. 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 New Mexico VA Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

[3] Danae F. Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The New Mexico VA Health Care System includes the Raymond G. Murphy VA Medical Center (Albuquerque) and associated outpatient clinics in Colorado and New Mexico. General information about the healthcare system can be found in appendix B. The inspection team examined operations from May 20, 2017, through February 18, 2022, the last day of the unannounced multiday evaluation.[5]

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 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 New Mexico VA Health Care System occurred in May 2017. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in February 2020.

[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 (interim Director); acting Associate Director; acting Assistant Director; acting Associate Director, Patient Care Services; and Chief of Staff.[10] The Chief of Staff and acting Associate Director, Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for less than two months, although the Chief of Staff had served in the role since 2016. To help assess the executive leaders' engagement, the OIG interviewed the interim Director; Chief of Staff; acting

[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.

[10] On November 30, 2021, prior to the OIG's inspection, the Associate Director was detailed as the interim Director; the Assistant Director then became the acting Associate Director on December 19, 2021; and the Chief, Engineering Service was assigned as the acting Assistant Director on January 10, 2022.

Associate Director, Patient Care Services; and acting 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 $682,116,564 had increased by almost 10 percent compared to the previous year's budget of $622,070,714.[11] The interim Director stated the budget was adequate overall. The interim Director and acting Associate Director reported challenges with adequate funding to hire staff to match the workload. The acting Associate Director described not having funding to provide incentives or retention pay for nurses and stated leaders spent a significant portion of the medical budget for contract staff such as intensive care unit nurses.

Employee Satisfaction

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

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

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

[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).

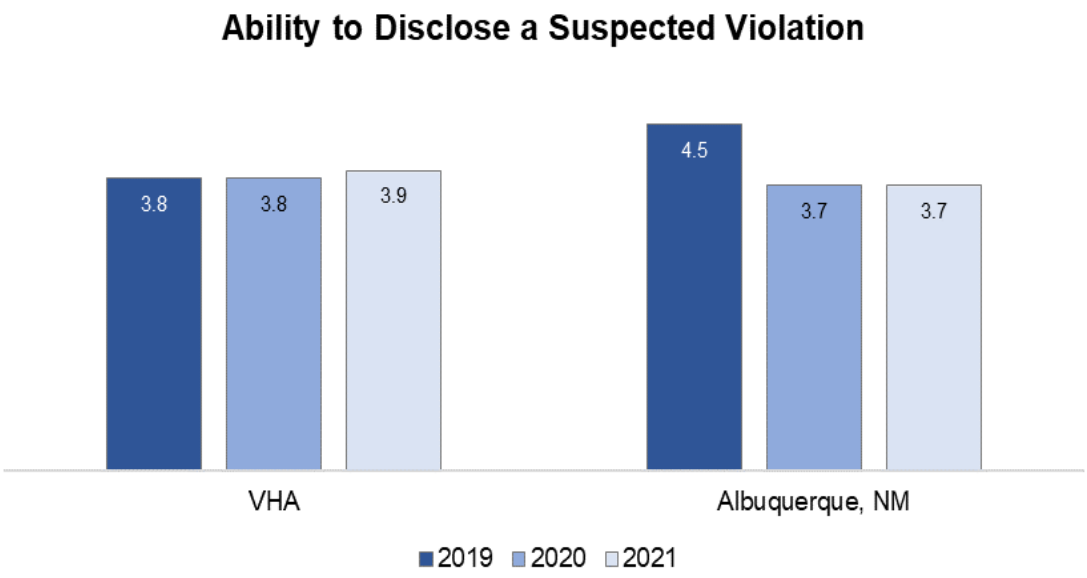

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed January 10, 2022).

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 FYs 2018 through 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.

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

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

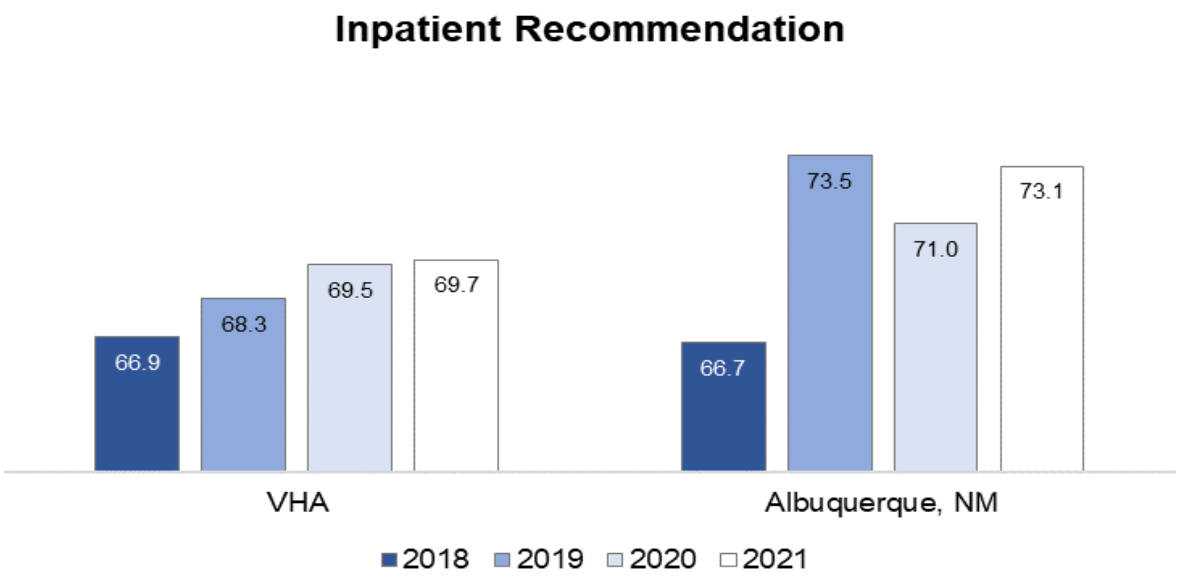

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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

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

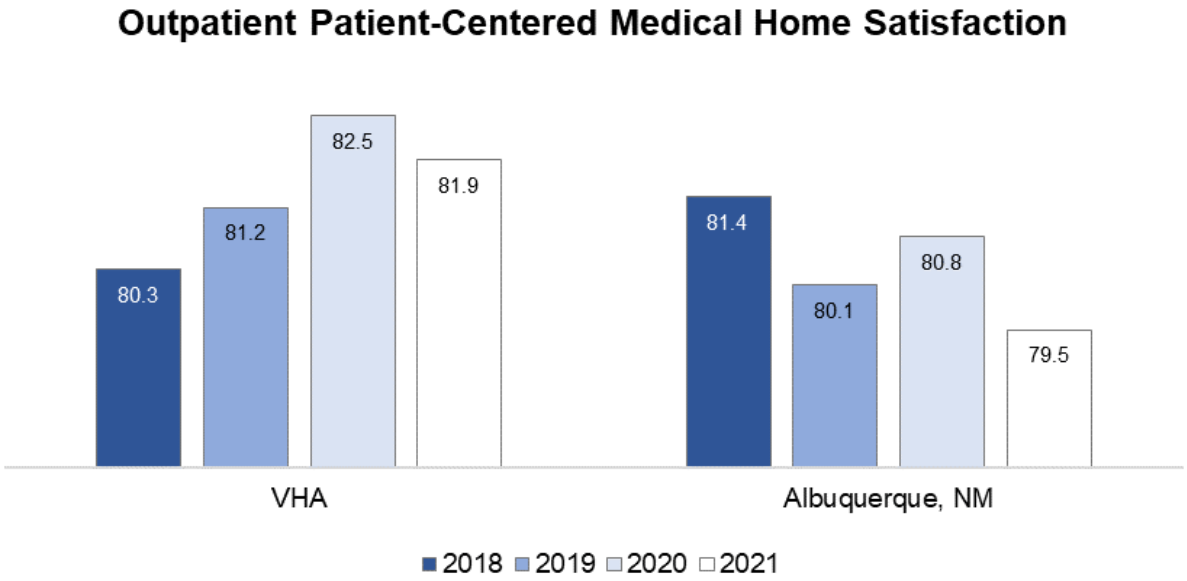

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

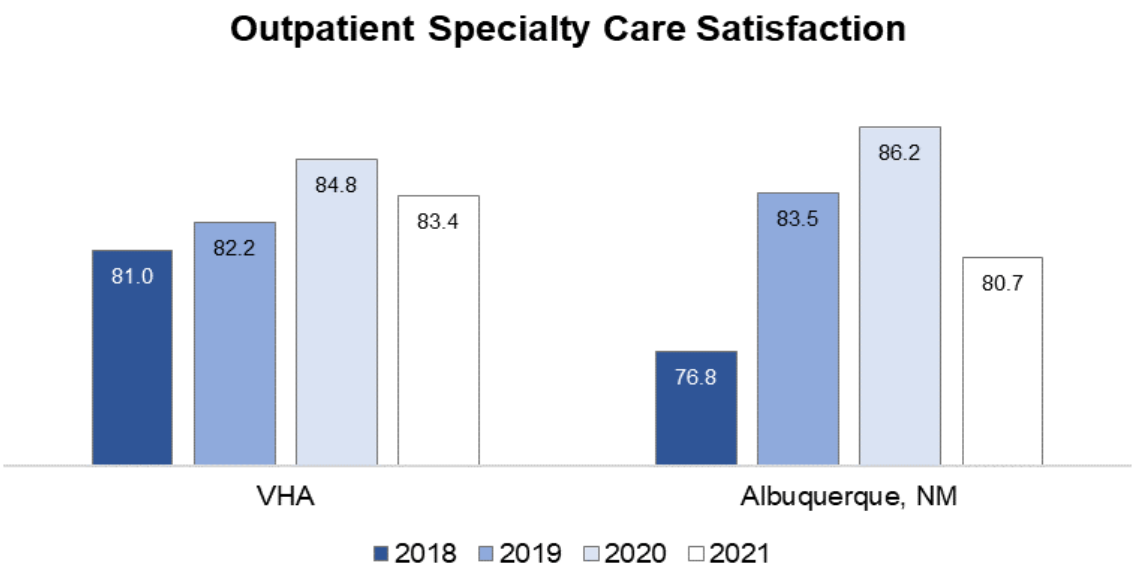

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders' Responses

Leaders must ensure 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 affected by an adverse event resulting from a systems issue."[20] To this end, VHA implemented

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

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

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

[20] VHA Directive 1004.08.

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 (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 OIG reviewed sentinel events and institutional and large-scale disclosures that occurred from May 20, 2017 (the prior OIG CHIP site visit), to February 14, 2022. The interim Director reported being aware of patient safety issues and was generally knowledgeable regarding processes for institutional disclosures and actions taken in response to sentinel events.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

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

Quality, Safety, and Value

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

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

Finally, the OIG assessed the healthcare system's culture of safety.[29] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

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

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

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

[25] VHA Directive 1100.16.

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

[27] VHA Directive 1190.

[28] VHA Directive 1190.

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

Quality, Safety, and Value Findings and Recommendations

TJC's standards state that facilities' governing bodies should provide oversight, structure, and resources to support quality and safety. TJC's standards also state that facility staff collect and analyze data so that performance improvement "effectiveness can be sustained, assessed, and measured."[30] The OIG found that from January 1 through December 31, 2021, two of two sets of Executive Leadership Board meeting minutes lacked evidence the board recommended, implemented, or monitored improvement actions. This could have prevented improvements in quality care and patient safety processes. The Executive Assistant to the Director and Chief of Quality and Patient Safety stated that, due to organizational issues that were exacerbated by the COVID-19 pandemic and turnover in executive leadership positions, Executive Leadership Board meetings were inconsistent and lacked structured content.

Recommendation 1

1. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures the Executive Leadership Board recommends, implements, and monitors improvement actions.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: The Executive Director reviewed the recommendation and did not identify any additional reasons for noncompliance. The Executive Leadership Council (ELC) monitors the reporting committee's minutes and recommends follow-up actions as part of the governance structure. The ELC established a reporting schedule for reporting bodies to include the minimum requirements for these reports. The ELC tracks recommendations, implementation, and monitoring of improvement actions. The ELC established a quorum protocol and maintains the minutes of these meetings. The Executive Assistant to the Executive Director will monitor compliance until 90 percent compliance is achieved and sustained for six (6) consecutive months. Compliance will be reported to the Quality Board (QB) through the governance structure.

VHA requires the peer review committee to complete a final review of peer review cases and recommend "non-punitive, non-disciplinary actions to improve the quality of health care delivered."[31] The OIG found that most of the final Level 3 peer reviews examined did not

[30] The Joint Commission, *Standards Manual*, E-dition, LD.01.03.01, LD.03.05.01, LD.03.07.01 through LD.04.03.11, and PI.01.01.01 through PI.03.01.01.

[31] VHA Directive 1190.

contain evidence the Protected Peer Review Committee recommended improvement actions.[32] This could have prevented providers from improving their patient care practices. The Chief of Staff and Peer Review Specialist stated the Protected Peer Review Committee sent feedback letters to the providers informing them of the peer review results and reported believing this met the requirement.

Recommendation 2

2. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures the Protected Peer Review Committee recommends improvement actions for Level 3 peer reviews.[33]

Healthcare system concurred.

Target date for completion: Complete

Healthcare system response: The Executive Director reviewed the recommendation and did not identify any additional reasons for noncompliance. After the February 2022 OIG CHIP review, Protected Peer Review Committee (PPRC) members discussed improvements in the process and how the Service would respond to the PPRC when the Service or individual involved completed the improvement action. Beginning May 2022, the new strategy includes recording a PPRC recommended improvement action in the PPRC minutes for each final Level 3 voted on in the PPRC meeting. Compliance of 90 percent sustained for six (6) consecutive months was achieved in March 2023.

VHA requires that "all events receiving an actual or potential SAC [safety assessment code] score of three receive either an individual RCA [root cause analysis] or must be included in an Aggregated Review."[34] The OIG found that for many of the events that occurred from January 1 through December 31, 2021, and had a potential safety assessment code score of three, staff did not complete an individual root cause analysis or include the event in an aggregated review. When staff do not complete root cause analyses, they are less likely to identify and mitigate system vulnerabilities that may eventually harm patients. The Patient Safety Manager cited a misinterpretation of the VHA policy and reported believing that only events with an

[32] A Level 3 designation is for when "most experienced and competent clinicians would have managed the case differently." VHA Directive 1190.

[33] The OIG reviewed evidence sufficient to demonstrate that healthcare system staff completed improvement actions and therefore closed the recommendation before publication of the report.

[34] Staff assign safety assessment codes to patient safety events based on severity and potential harm. A score of "3" is considered the highest risk. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded this handbook and replaced it with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

actual safety assessment code score of three required a root cause analysis and screening the events for inclusion in an aggregated review met the requirement.

Recommendation 3

3. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures staff either conduct an individual root cause analysis for all events receiving an actual or potential safety assessment code score of three or include the events in an aggregated review.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: The Executive Director reviewed the recommendation and did not identify any additional reasons for noncompliance. On February 22 through February 25, 2022, Patient Safety Managers conducted a review and reeducation of VHA Handbook 1050.01, National Patient Safety Improvement Handbook, dated March 4, 2011, Appendix B "The Safety Code (SAC) Matrix." Patient Safety Managers established a Joint Patient Safety Report (JPSR) local report to review all patient safety events that received a potential safety assessment code of three to audit compliance for an individual root cause analysis or inclusion of the event in an aggregated review. Patient Safety will report monthly audits of JPSR events receiving an actual or potential safety assessment code of three (3) and root cause analysis or aggregated review compliance to the Patient Safety Committee. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. Compliance will be reported to the Quality Board (QB) through the governance structure.

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."[35] 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."[36]

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.[37] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[38]

VHA defines the Focused Professional Practice Evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[39] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[40] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation (OPPE) to ensure the continuous delivery of quality care.[41]

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.[42] 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

[35] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded this handbook and replaced it 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.)

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Handbook 1100.19.

[42] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[43]

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

- Three solo or few practitioners who underwent clinical privileging[44]
- Five LIPs who had an FPPE completed
- Twenty LIPs who were reprivileged

Medical Staff Privileging Findings and Recommendations

VHA requires that "another provider with similar training and privileges" completes LIPs' professional practice evaluations.[45] For two of five FPPEs reviewed, the OIG could not determine whether a similarly trained and privileged provider completed the evaluations as they did not include the reviewer's name. When similarly trained and privileged providers do not evaluate practitioners' professional practice, it could compromise patient safety. The Chief of Staff reported believing the two FPPEs met requirements.

[43] 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.

[44] VHA refers to a solo practitioner as being one provider in the facility who is privileged in a particular specialty. VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners," August 29, 2016. (This memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on December 18, 2020. The December 18, 2020, memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on May 18, 2021.) The OIG considers few practitioners as being two providers in the facility who are privileged in a particular specialty.

[45] VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners." 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." 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."

Recommendation 4

4. The Chief of Staff determines the reasons for noncompliance and ensures providers with similar training and privileges complete licensed independent practitioners' Focused Professional Practice Evaluations.

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. The NMVAHCS [New Mexico VA Health Care System] updated all Focused Professional Practice Evaluation (FPPE) Chart Review and Summary Forms on April 1, 2022, to comply with the VHA Mandated Implementation of Enterprise-Wide FPPE Specialty Specific Clinical Indicators. The Service reviews this information to ensure that the reviewer has the same specialty and expertise to review the selected provider. Credentialing and Privileging Office will conduct audits to ensure that the reviewer has the same specialty and expertise to review the selected provider. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. Compliance will be reported to the Quality Board (QB) through the governance structure.

VHA requires that service chiefs' recommendations to continue current privileges be based, in part, on OPPE activities such as direct observation and clinical reviews and discussions.[46] The OIG did not find evidence from the inconsistently collected data that service chiefs recommended continued privileges based, in part, on OPPE activities. This may have resulted in LIPs continuing to deliver care without thorough evaluations of their practice. The Chief of Staff attributed the noncompliance to a lack of clear processes and tracking, in addition to staff turnover within some services.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs recommend licensed independent practitioners' continued privileges based on Ongoing Professional Practice Evaluation activities.

[46] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. The NMVAHCS updated all Ongoing Professional Practice Evaluation (OPPE) Chart Review and Summary Forms on April 1, 2022, to comply with the VHA Mandated Implementation of Enterprise-Wide OPPE Specialty Specific Clinical Indicators. The updated OPPE Summary Forms include an area in which the Service Chief recommends privileges be continued, limited, or revoked as part of the overall evaluation of OPPE results. Credential and Privileging Office will conduct audits to ensure that service chiefs recommend privileges are continued, limited, or revoked based, in part, on OPPE activities. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. Compliance will be reported to the Quality Board (QB) through the governance structure.

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.[47] 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. The OIG assessed compliance in selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[48]

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.[49] 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.[50]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 11 patient care areas:

- Ambulatory surgery/post-anesthesia care unit

[47] 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.)

[48] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008.

[49] 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.

[50] 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.

- Community Living Center (Bldg. 80)
- Emergency Department
- Geriatric Mental Health (6C)
- Inpatient Mental Health (Ward 7, Bldg. 3)
- Medical/surgical units (3A and 5A)
- Primary Care Outpatient Clinic
- Surgery/Orthopedics/Vascular/Cardiology
- Surgical Intensive Care Unit
- Women's Health Clinic

Environment of Care Findings and Recommendations

TJC standards specify that hospital staff conduct and document maintenance, inspection, and testing of all medical equipment in accordance with manufacturers' recommendations.[51] The OIG found that biomedical equipment was overdue for inspection in 3 of 11 areas. Inaccurately calibrated or malfunctioning equipment may lead to inappropriate medical decisions or patient harm. The Chief of Biomedical Engineering stated that staff would implement new processes with unit-level surveillance until a new equipment tracking system was online and biomedical engineering staffing improved.

Recommendation 6

6. The Assistant Director determines the additional reasons for noncompliance and ensures staff maintain, inspect, and test biomedical equipment according to the manufacturer's recommendations.[52]

[51] The Joint Commission, *Standards Manual*, E-dition, EC.02.04.01, January 1, 2022.

[52] The OIG reviewed evidence sufficient to demonstrate that healthcare system staff completed improvement actions and therefore closed the recommendation before publication of the report.

Healthcare system concurred.

Target date for completion: Complete

Healthcare system response: The Associate Director reviewed the recommendation and did not identify any additional reasons for noncompliance. Beginning February 22, 2023, the NMVHAHCS BioMedical Department initiated a facility-wide face-to-face in-service on Preventative Maintenance (PM) Labels usage and verification, including a posted laminated 'label identification' with instructions for equipment usage. BioMedical followed with monthly Clinical Engineering technicians and engineers rounding of areas throughout the facility to identify and correct out of compliance items. Compliance was reported to Environment of Care (EOC) Committee. Compliance of 90 percent sustained for six (6) consecutive months was achieved in January 2023.

Because "shipping cartons may harbor microorganisms and are considered contaminated," VHA requires staff to remove clean or sterile packaged items from shipping cartons and corrugated boxes before bringing them into clean storage areas.[53] The OIG found corrugated cardboard boxes in 4 of 11 areas inspected. Storage of clean and dirty items together increases the risk of cross contamination and transmission of microorganisms to patients. The nurse managers of the respective areas reported being unaware of the requirement to remove supplies from shipping cartons or corrugated boxes.

Recommendation 7

7. The Associate Director and Associate Director, Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure staff remove supplies from shipping cartons and corrugated boxes prior to putting them in clean storage areas.

[53] VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: The Associate Director and Associate Director, Patient Care Services reviewed the recommendation and did not identify any additional reasons for noncompliance. The NMVHAHCS Health System Specialist for the Associate Director, Patient Care Services coordinated clean sweeps across the facility, ensuring all corrugated boxes were removed. On February 22 through 24 2022, Nurse Managers received education to keep storage areas clean of boxes when supplies are delivered. Environment of Care (EOC) Committee will report monthly audits for Performance Logic (PL) deficiencies of corrugated cardboard found during weekly rounding. Compliance will be monitored until 90 percent compliance is achieved and sustained for six (6) consecutive months. Compliance will be reported to the Quality Board (QB) through the governance structure.

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."[54] 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."[55]

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.[56] 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."[57] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from the Emergency Department or urgent care center 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 50 randomly selected patients who were seen in the Emergency Department or urgent care center from December 31, 2020, through August 1, 2021.

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

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

[56] 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.)

[57] 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 the 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

The OIG made no recommendations.

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 seven 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 seven OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Executive Director; Chief of Staff; Associate Director, Patient Care Services; Associate Director; and Assistant Director. 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	• None
Quality, Safety, and Value	• The Executive Leadership Board recommends, implements, and monitors improvement actions. • The Protected Peer Review Committee recommends improvement actions for Level 3 peer reviews. • Staff either conduct a root cause analysis for all events receiving an actual or potential safety assessment code score of three or include the events in an aggregated review.
Medical Staff Privileging	• Providers with similar training and privileges complete licensed independent practitioners' Focused Professional Practice Evaluations. • Service chiefs recommend licensed independent practitioners' continued privileges based on Ongoing Professional Practice Evaluation activities.
Environment of Care	• Staff maintain, inspect, and test biomedical equipment according to the manufacturer's recommendations. • Staff remove supplies from shipping cartons and corrugated boxes prior to putting them in clean storage areas.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• None

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1b) affiliated healthcare system reporting to VISN 22.[1]

Table B.1. Profile for New Mexico VA Health Care System (501)
(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	$526,765,358	$622,070,714	$682,116,564
Number of:			
• Unique patients	59,863	55,968	59,337
• Outpatient visits	660,760	590,470	632,164
• Unique employees§	2,322	2,304	2,269
Type and number of operating beds:			
• Community living center	36	36	36
• Domiciliary	80	70	70
• Medicine (hospital)	70	70	70
• Mental health	36	36	36
• Residential rehabilitation	5	5	5
• Spinal cord	26	26	26
• Surgery	35	35	35
Average daily census:			
• Community living center	14	14	10
• Domiciliary	50	36	17
• Medicine	49	55	55
• Mental health	20	21	22
• Residential rehabilitation	3	3	2
• Spinal cord	19	17	13

[1] VHA medical facilities are classified according to a complexity model; a designation of "1b" indicates a facility with "medium-high volume, high risk patients, many complex clinical programs, and medium-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	10	9	8

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 26, 2023

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Comprehensive Healthcare Inspection of the New Mexico VA Health Care System in Albuquerque

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

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) Draft Report, Comprehensive Healthcare Inspection of the New Mexico VA Healthcare System in Albuquerque, NM.
2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted action plans of the New Mexico VA Healthcare System.
3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(Original signed by:)

Michael W. Fisher
VISN 22 Network Director

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: April 25, 2023

From: Director, New Mexico VA Health Care System (501/00)

Subj: Comprehensive Healthcare Inspection of the New Mexico VA Health Care System in Albuquerque

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of the VA New Mexico Healthcare System in Albuquerque. I concur with the findings and recommendations in the report.
2. VA New Mexico Healthcare System remains committed to ensuring our Veterans receive exceptional health care.

(Original signed by:)

Sonja Y. Brown for:
Robert McKenrick
Executive Director, VA New Mexico Healthcare System

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