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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Southern Arizona VA Health Care System in Tucson

CHIP Report | 22-00054-158 | August 2, 2023

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Figure 1. *Tucson VA Medical Center of the Southern Arizona VA Health Care System.*

Source: https://www.va.gov/southern-arizona-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
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 Southern Arizona VA Health Care System, which includes the Tucson VA Medical Center and multiple outpatient clinics in Arizona. 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 Southern Arizona VA Health Care System during the week of March 21, 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 six recommendations to the Director in the following areas of review: Leadership and Organizational Risks, Environment of Care, and Mental Health. These results are detailed throughout the report and summarized in appendix A on page 25.

Conclusion

The OIG issued six recommendations for improvement to the 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 leaders to use recommendations as a road map to help improve operations and clinical care moving forward. 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 interim Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 28–29, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 3 and 4 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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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 Southern Arizona 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 Southern Arizona VA Health Care System includes the Tucson VA Medical Center and associated outpatient clinics in Arizona. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from October 17, 2016, through March 25, 2022, the last day of the unannounced multiday evaluation.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last Clinical Assessment Program review occurred in October 2016. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in March 2017 and 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 Director, Associate Director, Assistant Director, Associate Director of Patient Care Services, and Chief of Staff. The Chief of Staff and Associate Director of 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 approximately five months. All staff were permanently assigned except for the Acting Associate Director, who had been in the role since October 2021.[10]

[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 et al., *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] During the inspection week, the Chief of Staff was on leave, so the OIG interviewed the Deputy Chief of Staff.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $753,918,917 increased by approximately 14 percent compared to the previous year's budget of $659,034,148.[11] The Director reported plans for an 8,000 square foot expansion of the Emergency Department. The Acting Associate Director mentioned using funds to renovate the mental health inpatient unit, vaccination clinic, and morgue.

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).

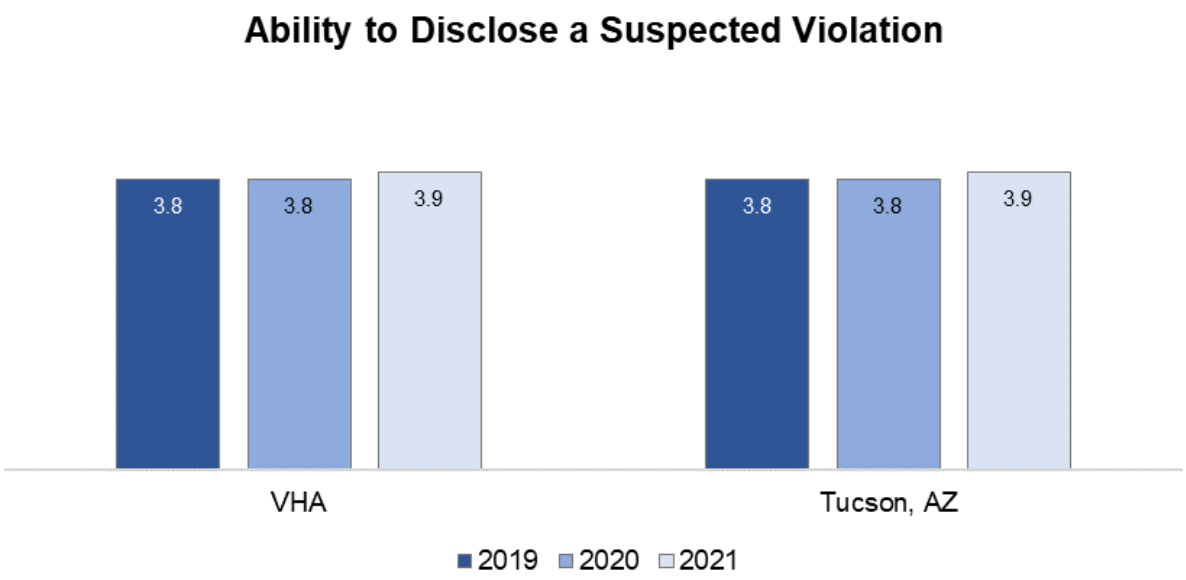

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed February 16, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

Veterans Health Administration (VHA) uses 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.

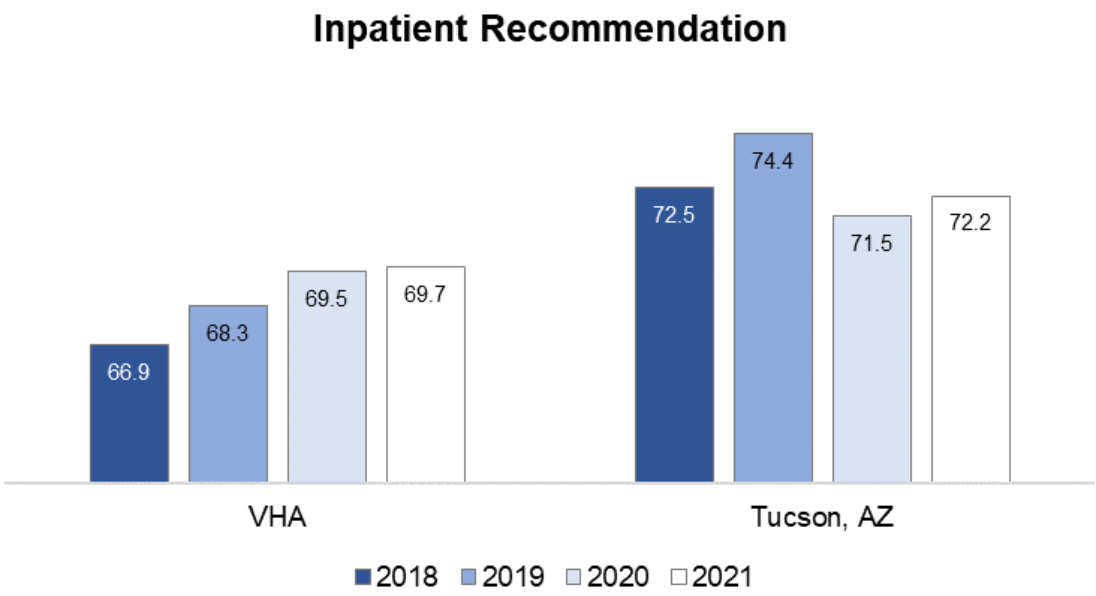

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

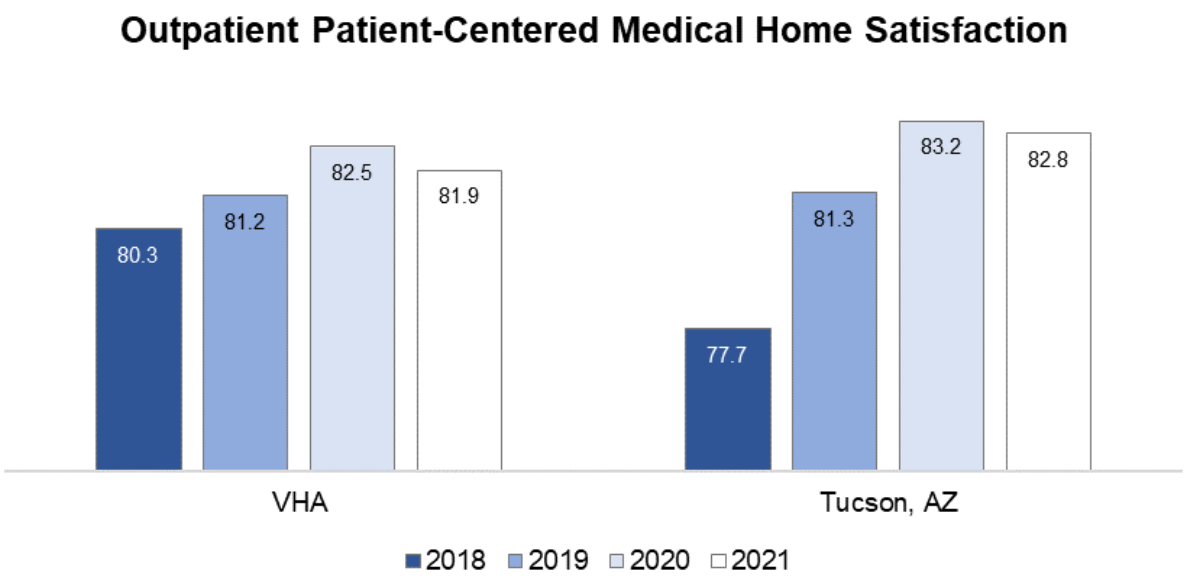

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

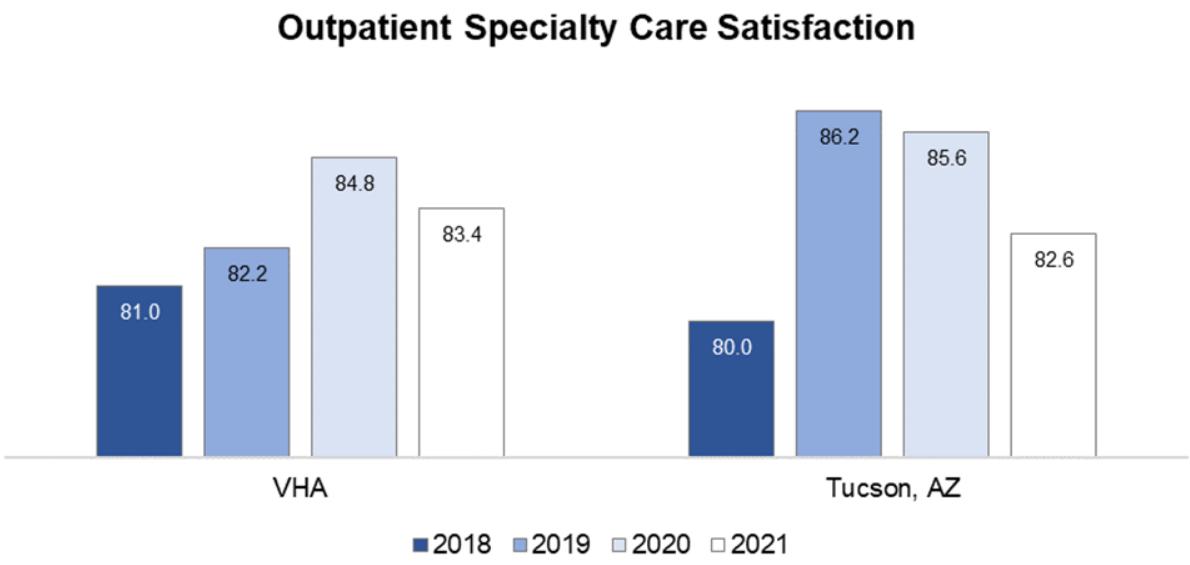

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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 a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[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

[17] Frankel et al., *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] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in 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.

with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[20] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

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

The Director stated that staff shared patient safety events through daily reports; huddles; and via communication from the Chief of Quality, Safety, and Value; Risk Manager; or others. The Director described the disclosure process as a collaboration between the Risk Manager, Chief of Staff, and Associate Director of Patient Care Services. The Risk Manager explained that the institutional disclosure process included a determination whether the event resulted in death, permanent harm, or severe injury.

The OIG reviewed sentinel events and institutional and large-scale disclosures reported by the Patient Safety and Risk Managers that occurred since October 17, 2016 (the prior OIG Clinical Assessment Program site visit). Although leaders were able to discuss the adverse event reporting process, the OIG noted concerns related to leaders conducting institutional disclosures.

Leadership and Organizational Risks Findings and Recommendations

VHA states that sentinel events "signal the need for immediate investigation and response."[23] VHA requires that when "an adverse event has resulted in or is reasonably expected to result in death or serious injury, an institutional disclosure must be performed regardless of when the event is discovered."[24] The Patient Safety and Risk Managers provided the OIG with a list of sentinel events and institutional disclosures. The OIG found that leaders did not complete institutional disclosures for those sentinel events that may have contributed to patient deaths. Failure to conduct institutional disclosures may reduce patients' trust in the organization. The

[20] VHA Directive 1004.08.

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

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

[23] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

[24] VHA Directive 1004.08.

Risk Manager did not have documentation regarding why leaders did not conduct institutional disclosures.

Recommendation 1

1. The Director evaluates and determines any additional reasons for noncompliance and ensures leaders evaluate sentinel events and conduct institutional disclosures when criteria are met.

Healthcare system concurred.

Target date for completion: December 30, 2023

Healthcare system response: The Director reviewed the recommendation and did not identify any additional reason for noncompliance. The Chief of Quality, Safety and Value (QSV) reviewed the recommendation and implemented improvements in the institutional disclosure process. Upon discovery of a sentinel event, Quality and Patient Safety staff informs the Chief of Staff and/or the Associate Director of Patient Care Services. If an institutional disclosure is warranted, the decision is discussed and made by the Chief of Staff and/or Associate Director of Patient Care Services. In addition, Quality and Patient Safety staff will review all adverse events in order to ensure all components of the process have taken place. The Quality and Patient Safety staff will report quarterly compliance with the completion of the applicable institutional disclosures to the Quality Safety Value Board (QSVB). A secure database was created to track adverse events. The Quality and Patient Safety staff will document the indication for institutional disclosure in this database. The numerator equals total # of Institutional Disclosures (ID) given. The denominator equals total # of Sentinel Events. If a disclosure is not able to be completed, the reason will be noted in the database and tracked in the action plan. Compliance will be monitored until 90 percent is achieved and sustained for six consecutive months.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[25] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[27]

To determine whether 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. (VHA rescinded and replaced this directive with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, on July 19, 2022.)

[27] VHA Directive 1100.16.

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

[29] VHA Directive 1190.

[30] VHA Directive 1190.

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

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[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 (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[36] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[37] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[38]

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

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

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Directive 1100.20.

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

The OIG interviewed key managers and selected and reviewed the privileging folders of 30 medical staff members who had a completed FPPE or Ongoing Professional Practice Evaluation.

Medical Staff Privileging Findings and Recommendations

The OIG noted that the credentialing office reported being understaffed by two full-time equivalent employees. This level was below the benchmark of one full-time equivalent employee per 300 active non-LIP credentialing files, as specified in the September 10, 2020, Assistant Under Secretary for Health for Operations memorandum.[41]

VHA requires the Chief of Staff to ensure FPPE process criteria are "defined in advance, using objective criteria accepted by the practitioner."[42] The OIG reviewed 10 LIP folders and found that 9 FPPEs lacked evidence the LIPs were aware of and had accepted the evaluation criteria before service chiefs initiated the process. This could have resulted in LIPs misunderstanding FPPE expectations. The Deputy Chief of Staff reported the process had been that service chiefs had verbal conversations with newly hired practitioners but did not document them. The OIG did not make a recommendation, but without VHA requiring documentation that practitioners were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

[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] Assistant Under Secretary for Health for Operations memo, "Credentialing and Privileging Staffing Modernization Efforts—Re-alignment of Licensed Independent Providers (LIP) and Non-LIP Functions at Department of Veterans Affairs Medical Centers (VAMC)," September 10, 2020.

[42] VHA Handbook 1100.19.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[43] The physical environment of a healthcare organization must not only be functional but should also promote healing.

The purpose of this inspection was to determine whether 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.[44]

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.[45] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times in emergencies and contribute to a safe healthcare environment.[46]

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

- Community Living Center (hospice and palliative care)

[43] 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.)

[44] 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.

[45] 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.

[46] 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.

- Emergency Department
- Intensive care unit (Building 38)
- Medical/surgical inpatient unit (3 North)
- Mental health inpatient unit (1 West)
- Primary care clinic (Saguaro)

Environment of Care Findings and Recommendations

VHA requires facilities to have a comprehensive environment of care coordinator and program, which includes staff conducting inspections at "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year" in patient care areas and documenting completion of each inspection. Additionally, VHA states the environment of care coordinator is responsible for coordinating and scheduling physical inspections and maintaining records using the Comprehensive Environment of Care Assessment and Compliance Rounding tool.[47]

The OIG reviewed the healthcare system's FY 2021 environment of care inspections. Some community-based outpatient clinics underwent only one inspection during the FY, and some had no evidence of any completed inspections. The Chief of Environmental Management Service stated that outpatient clinic site managers were supposed to coordinate with an Environment of Care Committee member to input the inspection information in the database. The Acting Associate Director and the Chief of Environmental Management Service attributed the deficiency to lack of oversight in ensuring staff completed this process.

Recommendation 2

2. The Director determines any additional reasons for noncompliance and ensures the Comprehensive Environment of Care Coordinator or designee schedules and ensures staff complete environment of care inspections in patient care areas at the required frequency and document the inspection results.

[47] VHA Directive 1608; Department of Veterans Affairs (VA) Veterans Health Administration (VHA) Environmental Programs Service (EPS), *Environment of Care (EOC) Assessment and Compliance Rounding Process Guide*, August 3, 2014.

Healthcare system concurred.

Target date for completion: October 1, 2023

Healthcare system response: The Director reviewed the recommendation and did not identify any additional reason for noncompliance. The Community Based Outpatient Clinics (CBOC) schedule was altered, and process adjustments were made due to the Coronavirus Disease of 2019 (COVID 19). Documentation of inspection results were not in the Comprehensive Environment of Care Assessment and Compliance Rounding Tool but were documented manually for CBOCs for the virtual inspection. This process was discontinued as of March 2022. CBOCs environment of care inspections were scheduled, and staff completed environment of care inspections in patient care areas at the required frequency for May 2022 to May 2023. Subsequent inspections for the entire facility were conducted as prescribed in VHA Directive 1608 Comprehensive Environment of Care (CEOC) Program as of April 2022 and reported to the Environment of Care (EOC) Committee. The compliance rate for conducting inspections is 90% or greater for 12 months.

VHA also requires the Director to ensure any deficiencies and improvement opportunities identified during comprehensive environment of care inspections are "tracked until resolved, in accordance with procedures established by the CEOC [Comprehensive Environment of Care] Steering Committee."[48] The OIG reviewed the system's environment of care deficiency list for the previous six months and identified that staff had not always completed or developed action plans to resolve the issues. Incomplete resolution of deficiencies could potentially pose threats to the physical safety and well-being of patients, staff, and visitors. The Chief of Environmental Management Service attributed the noncompliance to a lack of oversight while on unplanned leave.

Recommendation 3

3. The Director determines any additional reasons for noncompliance and ensures the Comprehensive Environment of Care Coordinator or designee tracks environment of care inspection deficiencies until they are resolved.[49]

[48] VHA Directive 1608.

[49] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Director reviewed the recommendation and did not identify any additional reason for noncompliance. The facility has designated the Chief and the Program Support Assistant of Environmental Management Service, as the Environment of Care (EOC) Rounds Coordinators to ensure inspections are conducted, documented, tracked, and trended in the Comprehensive Environment of Care Assessment and Compliance Rounding Tool. The EOC Rounds Coordinators also reported out as a standing agenda item to the EOC Committee monthly to ensure deficiencies are tracked until resolved, starting in May 2022 and continue to do so.

The facility would like to request closure for the recommendation prior to publication based on supporting evidence provided to the Office of Inspector General (OIG).

The Occupational Safety and Health Administration requires staff to post hazard warning signs where potentially infectious materials are present.[50] The OIG identified four areas that lacked appropriate signage indicating storage of potentially infectious materials, which could place patients, staff, and visitors at risk for exposure.[51] The Safety Officer reported being unaware of the requirement for signage to be placed on the door.

Recommendation 4

4. The Director determines any additional reasons for noncompliance and ensures staff post signage in all areas where potentially infectious materials are present.[52]

[50] Occupational Safety and Health Administration Standards, 29 C.F.R. § 1910.145(e)(4). "Biological hazard signs. The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents."

[51] The OIG identified missing hazard warning signs on the soiled utility rooms for the mental health inpatient, medical/surgical inpatient, and intensive care units and the Emergency Department.

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

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Director reviewed the recommendation and did concur with the recommendation. The Safety Office has completed a thorough review of the recommendation received from the OIG on June 6, 2023, identifying that soiled utility rooms lacked Biohazard Warning Signage affixed to the door. The OIG provided an Occupational Safety and Health Administration (OSHA) reference [29 CFR 1910.145 (e) (4)] which describes use of Biological Hazard signs. Soiled utility rooms at Southern Arizona VA Health Care System (SAVAHCS) are locked and signed to prevent access and inadvertent exposures to visitors and patients. Employees with a key to these rooms are also trained to properly handle biohazardous materials.

All soiled utility rooms were assessed, damaged/missing signage was replaced or installed. This was also reported to the Environment of Care Committee.

The facility would like to request closure for the recommendation prior to publication based on supporting evidence provided to the Office of Inspector General (OIG).

VHA requires the Director to follow Joint Commission requirements for ensuring hospital staff identify environmental deficiencies, hazards, and unsafe practices, and "keeps furnishings and equipment safe and in good repair."[53] The OIG found deficiencies in all six locations inspected, including dust that had accumulated on objects above eye level; scuffed and marked flooring; and storage of clean and dirty equipment together. Two areas had dirty ventilation grills; two had wall damage; one had unclean floors; two had dirty ceiling tiles; and one had a dirty bathroom with no functional light and previously used medication patches on the shower wall. These environmental conditions potentially adversely affect the physical safety and well-being of patients, staff, and visitors due to an increased risk of contamination and pathogen exposure. The Chief of Environmental Management Service explained that a lack of attention to detail contributed to these findings, and the Director reported that facility-wide construction had created multiple challenges.

Recommendation 5

5. The Director evaluates and determines any additional reasons for noncompliance and ensures staff keep patient care areas clean and furnishings and equipment safe and in good repair.

[53] VHA Directive 1100.16; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, IC.02.02.01.

Healthcare system concurred.

Target date for completion: December 30, 2023

Healthcare system response: The Director reviewed the recommendation and did not identify any additional reason for noncompliance. The deficiencies noted in all six locations were corrected. The locations were monitored for six months by Service points of contact to ensure sustainment and reported to the Environment of Care Committee.

The facility has established an approach to evaluate and determine any additional reasons for noncompliance and will ensure the Service Chiefs or designee in patient care areas will identify and report furnishings and equipment found unsafe and in need of repair according to the standard. At least weekly, the attendees (Senior Leaders throughout the healthcare system) will be encouraged during the Enterprise Daily Management System Huddle to elevate concerns regarding cleanliness, furnishings, and equipment in patient care areas. The Environment of Care Rounds Coordinator will track and report compliance monthly to the Environment of Care Committee. Compliance will be monitored until 90 percent is achieved and sustained for six consecutive months.

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 44 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 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 staff to conduct follow-up with patients who are identified as intermediate, high-acute, or chronic risk-for-suicide and have been recently discharged from the emergency department or urgent care center. Staff must maintain weekly telephone or in-person contact until the patient has attended one outpatient mental health appointment or is admitted to inpatient or residential care.[58] Of the selected patients, two were discharged from the Emergency Department, and one did not receive follow-up within seven days of discharge. Lack of follow-up may lead to a missed opportunity for staff to provide support, continue risk mitigation, ensure a smooth care transition, and monitor the continuity of care. The Associate Chief of Staff for Mental Health stated that competing patient care priorities during the COVID-19 pandemic, along with staffing challenges involving mental health providers and social workers in the Emergency Department, resulted in inconsistent completion of timely follow-up.

Recommendation 6

6. The Director evaluates and determines additional reasons for noncompliance and ensures staff conduct timely follow-up for intermediate, high-acute, or chronic risk-for-suicide patients who are discharged home from the Emergency Department.

Healthcare system concurred.

Target date for completion: December 30, 2023

Healthcare system response: The Director reviewed the recommendation and did not identify any additional reason for noncompliance. In late 2020, the SAVAHCS Mental Health Service (MHS) and Quality Management Team reviewed Columbia-Suicide Severity Rating Scale compliance in preparation for Fiscal Year 2021 Office of Inspector General Comprehensive Health Care Inspection Program. Based on initial audit findings, the Associate Chief of Staff for Mental Health recognized the need for additional support and dedicated staff to ensure Veterans discharging from the Emergency Department (ED) with elevated risk for suicide received appropriate, timely mental health follow-up in accordance with the Veterans Health Administration (VHA) Suicide Risk Identification Strategy. The Associate Chief of Staff for Mental Health engaged with the SAVAHCS Systems Redesign Team to initiate a Green Belt Project to evaluate and improve the SAVAHCS's processes for complying with the VHA Suicide Risk Identification Strategy, specifically safety planning in the ED, beginning on April 30, 2021. The Green Belt Project completed in October 2021 verified the need for additional resources to be fully successful. In October 2021, the Mental Health Service (MHS) applied for two special purpose funded positions to serve as Suicide Prevention Care

[58] 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."

Coordination Managers (SPCCM) from the Office of Mental Health and Suicide Prevention (OMHSP). In March 2022, the MHS was awarded the funding for 2.0 full time equivalent (FTE) Social Workers and started the recruitment process. On September 9, 2022, the MHS on-boarded the first SPCCM who required orientation, training, and development of new processes to assist with follow-up of discharged Veterans. The new processes started in December 2022. The SAVAHCS MHS will be on-boarding the second SPCCM on June 18, 2023. The SPCCM identifies Safety Planning in the Emergency Department (SPED) follow-up eligible Veterans via the VHA Support Service Center (VSSC) SPED Suicide Prevention Detail Report and makes follow-up calls on the same business day an eligible Veteran populates on the SPED Detail Report. Additionally, the SPCCM makes follow-up calls every week thereafter until the Veteran is engaged in mental health care, 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 SPCCM utilizes the Suicide Risk Management (SRM) Follow Up Note 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 six (6) consecutive months. Audit data will be reported to the Deputy Associate Chief of Staff for Mental Health, the facility Suicide Prevention Coordinator, the SPED Workgroup, and thru the Patient Flow 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 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 six 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 six OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director. The intent is for 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 sentinel events and conduct institutional disclosures when criteria are met.
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• The Comprehensive Environment of Care Coordinator or designee schedules and ensures staff complete environment of care inspections in patient care areas at the required frequency and document the inspection results. • The Comprehensive Environment of Care Coordinator or designee tracks environment of care inspection deficiencies until they are resolved. • Staff post signage in all areas where potentially infectious materials are present. • Staff keep patient care areas clean and furnishings and equipment safe and in good repair.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Staff conduct timely follow-up for intermediate, high-acute, or chronic risk-for-suicide patients who are discharged home from the Emergency Department.

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 Southern Arizona VA Health Care System (678) (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	$562,134,251	$659,034,148	$753,918,917
Number of:			
• Unique patients	59,298	58,668	61,827
• Outpatient visits	739,385	691,788	781,863
• Unique employees§	2,462	2,588	2,596
Type and number of operating beds:			
• Blind rehabilitation	31	31	31
• Community living center	90	90	90
• Domiciliary	25	25	25
• Medicine	76	76	76
• Mental health	31	31	31
• Surgery	36	36	36
Average daily census:			
• Blind rehabilitation	22	10	8
• Community living center	78	60	48
• Domiciliary	22	9	7
• Medicine	71	65	71
• Mental health	19	17	14

[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." "VHA 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	11	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: June 20, 2023

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

Subj: Comprehensive Healthcare Inspection of the Southern Arizona VA Health Care System in Tucson

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

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 Southern Arizona VA Healthcare System in Tucson, Arizona.
2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted action plans of the Southern Arizona VA Healthcare System.
3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(Original signed by:)

Steven E. Braverman, MD
Interim Network Director, VISN 22

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: June 5, 2023

From: Director, Southern Arizona VA Health Care System (678)

Subj: Comprehensive Healthcare Inspection of the Southern Arizona VA Health Care System in Tucson

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 Southern Arizona VA Healthcare System in Tucson. I have reviewed the recommendations and approve the responses and actions provided by our team.
2. Southern Arizona VA Healthcare System remains committed to ensuring our Veterans receive exceptional health care.

(Original signed by:)

Jennifer Gutowski, MHA, FACHE
Medical Center Director

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