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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System in California

CHIP Report | 22-00055-184 | August 24, 2023

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Figure 1. *West Los Angeles VA Medical Center of the VA Greater Los Angeles Healthcare System in California.*

Source: https://www.va.gov/greater-los-angeles-health-care/.

Abbreviations

ADPCS/NE	Associate Director, Patient Care Service/Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Greater Los Angeles Healthcare System, which includes the West Los Angeles VA Medical Center and multiple outpatient clinics throughout California. 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 VA Greater Los Angeles Healthcare System during the weeks of March 7 and March 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 nine recommendations to the Director; Chief of Staff; Associate Director, Patient Care Service/Nurse Executive; and Associate Director, Operations 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 the recommendations are summarized in appendix A on page 27.

Conclusion

The OIG issued nine recommendations for improvement to the Director; Chief of Staff; Associate Director, Patient Care Service/Nurse Executive; and Associate Director, Operations. The number of recommendations should not be used as a gauge for the overall quality of care provided within 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 Interim Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 30-31, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Greater Los Angeles Healthcare 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 (FY) 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The VA Greater Los Angeles Healthcare System provides care through the West Los Angeles VA Medical Center and associated outpatient clinics in California. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from February 11, 2019, through March 17, 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 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 VA Greater Los Angeles Healthcare System occurred in February 2019. The Joint Commission performed hospital, behavioral health, and home care accreditation reviews in July 2019.

[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 the following 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 Medical Center Director (Director); Deputy Medical Center Director (Deputy Director); Executive Director, Ambulatory Care Services; Associate Director, Resources; Associate Director, Operations; Associate Director, Patient Care Service/Nurse Executive (ADPCS/NE); and Chief of Staff. The Chief of Staff and ADPCS/NE 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 about one year, although four of the members had been in their positions since 2019. The Deputy Director was the last member assigned to the executive team, starting in March 2021. To help assess the executive leaders' engagement, the OIG interviewed the Director; Chief of Staff; ADPCS/NE;

[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.

Deputy Director; and Associate Director, Resources regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $1,424,653,901 had increased by approximately 16 percent compared to the previous year's budget of $1,224,147,279.[10] Executive leaders reported that the healthcare system received about $1.2 to $1.4 billion, mostly from funding related to the COVID-19 pandemic.[11] The Associate Director, Resources discussed using funds to buy cameras for virtual care and pay employees for contacting veterans to offer virtual appointments. The Director said leaders also used the money to hire contract employees to provide inpatient care during COVID-19 surges; build negative-pressure units; purchase medicine and medical supplies; and provide care, treatment, and rehabilitation services to veterans living in the system's tiny shelters.[12] The Director also reported using some of the funds to award employees for their contributions during the pandemic and returning several million dollars to the VISN, which was then used by other VA facilities.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

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

[11] The American Rescue Plan Act provided additional relief to "public health, state and local governments, individuals, and businesses" because of the continued effect of COVID-19 on the economy. American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 (2021). The purpose of the Coronavirus Aid, Relief, and Economic Security (CARES) Act was to keep "workers paid and employed," and provide "health care system enhancements" and "economic stabilization" due to the COVID-19 pandemic. CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020).

[12] "The VA Greater Los Angeles Healthcare System (VAGLAHS) is currently transitioning a portion of its current Care, Treatment and Rehabilitative Services (CTRS) initiative from tenting to tiny shelters," which are shelters that come "fully equipped and ready for occupancy, complete with a bed and mattress, fire life safety equipment, and air conditioning and heating." VA, "First Tiny Shelters Delivered to VA West LA Campus for Homeless Veterans," October 12, 2021, accessed October 13, 2022, https://www.va.gov/greater-los-angeles-health-care/news-releases/first-tiny-shelters-delivered-to-va-west-la-campus-for-homeless-veterans/.

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

To assess employees' attitudes toward the workplace, the OIG reviewed results from VA's All Employee Survey from FYs 2019 to 2021 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[14]

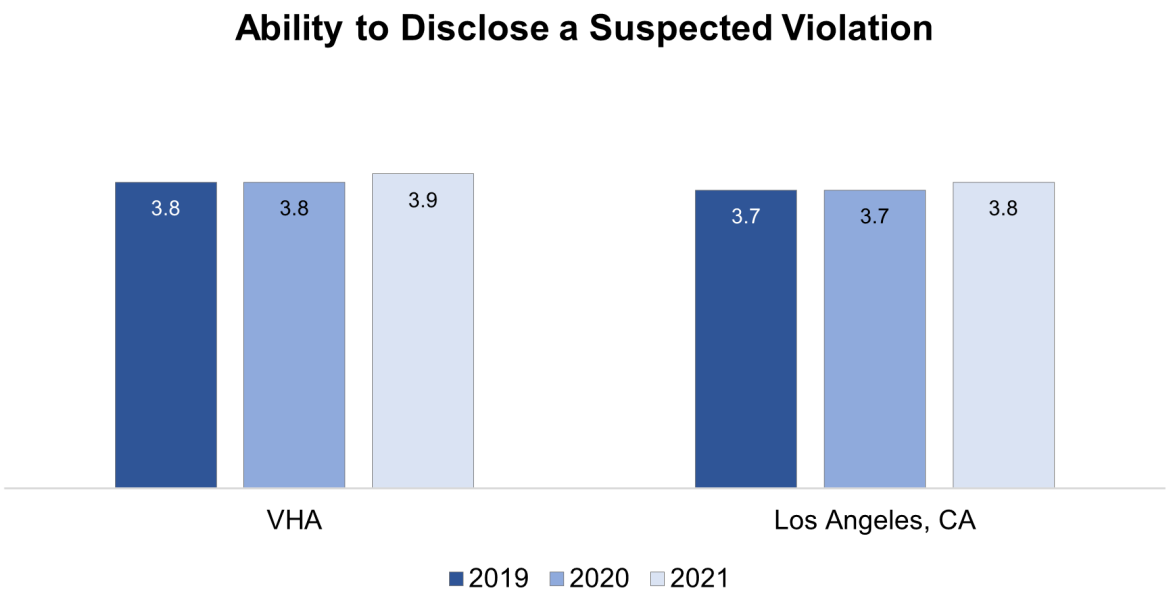

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed January 25, 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.[15]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[16] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare

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

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

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

system from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the healthcare system over time.[17]

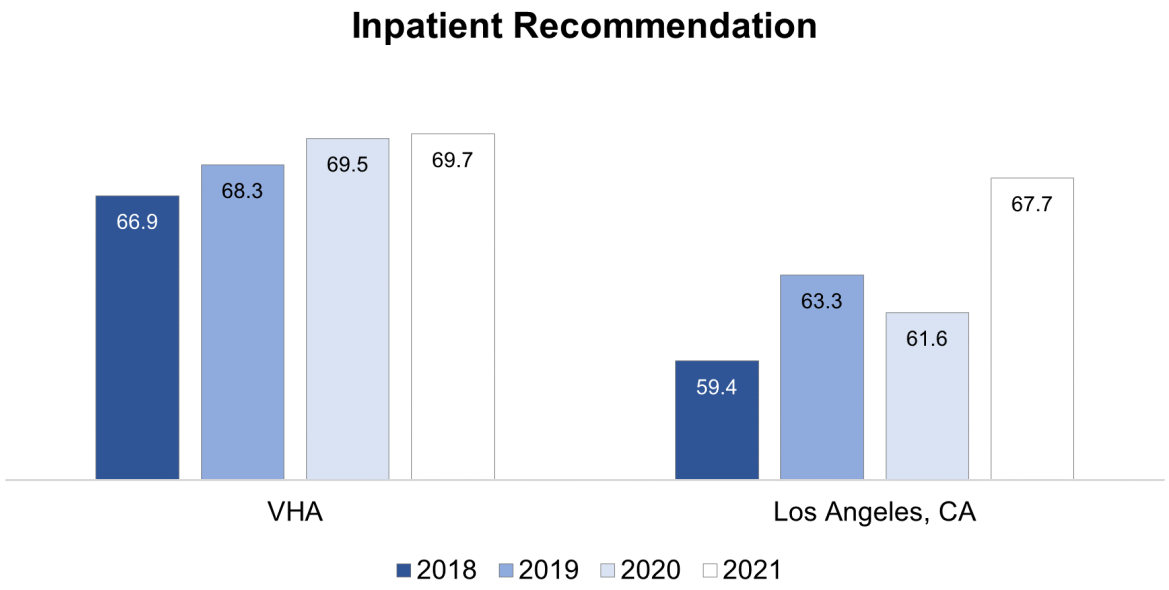

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

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

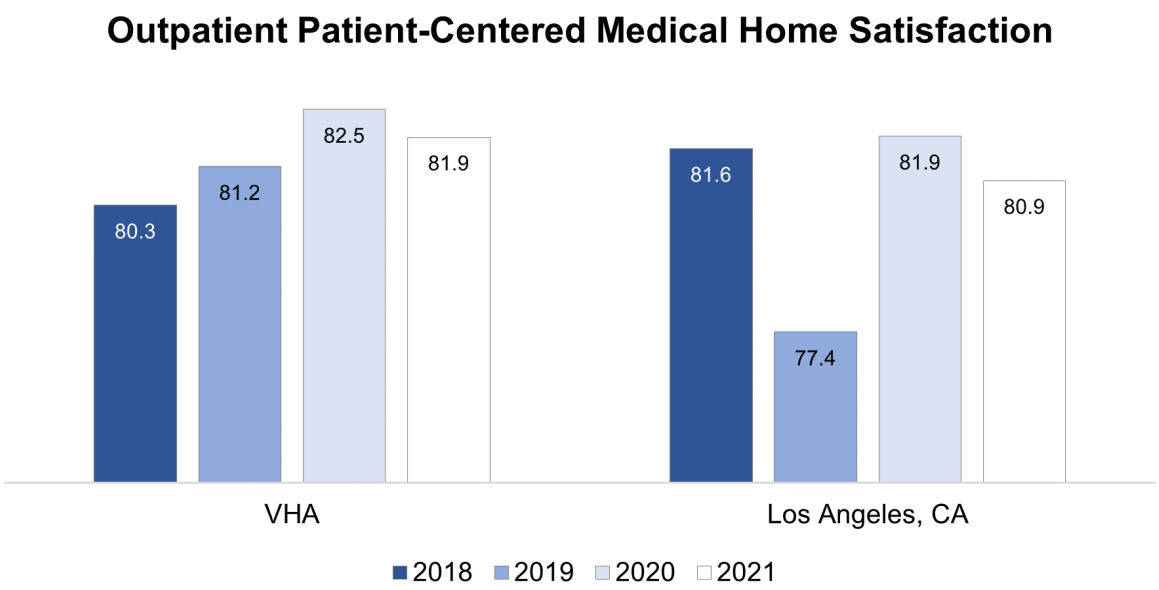

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

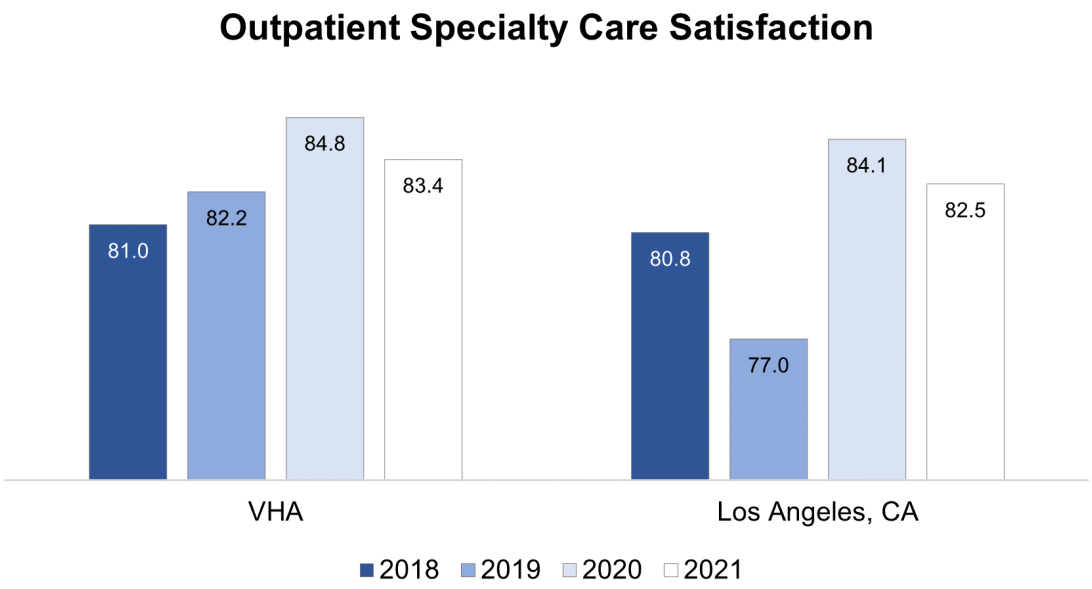

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.[18] "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)."[19] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and

[18] 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/.

[19] 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.

recourse."[20] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The 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.[22] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[23]

The OIG requested sentinel events, institutional disclosures, and large-scale disclosures that occurred since the last comprehensive healthcare inspection in February 2019. The Director spoke knowledgeably about the adverse event process, explaining that all staff are encouraged to report adverse events through the Joint Patient Safety Reporting system.[24] The Director further described providing *director's cards* to employees to assist them with making the right decision for veterans and said that executive leaders discuss high reliability organization principles during new employee orientation and endorse honest mistakes as learning opportunities.[25]

The Director also relayed that morning reports include discussion of patient safety events entered in the Joint Patient Safety Reporting system. The Director mentioned receiving a verbal report of the events that executive leaders, in consultation with the Chief, Quality Management, identified as potential sentinel events. The Director also said the Patient Safety Manager assigns safety

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

[21] VHA Directive 1004.08.

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

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

[24] VHA uses the Joint Patient Safety Reporting system for data management of patient safety events such as medical errors and close calls/near misses. "VHA National Center for Patient Safety," VA Health Care, accessed December 21, 2022, https://www.patientsafety.va.gov/about/faqs.asp.

[25] The *director's cards* have the "Four C's to success: communication, care of the veteran, customer service, and common sense" on one side, and "Go Ahead and Do it, Ask yourself: Is it good for my customer? Is it legally, morally, and ethically right? Does it fall within my area of responsibility? Will I be accountable for it? If yes, then do it!" on the other side. The OIG received a sample card from the Director on March 8, 2022. A high reliability organization "is an organization with a goal of achieving "zero harm" in an environment where accidents are expected due to complexity or risk factors." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program,* December 12, 2019.

assessment code scores for the events, and those events given an actual or potential score of 3 require a higher level of review.[26]

The Chief of Staff described the notification process as generally seamless. The Chief of Staff also said that executive leaders are familiar with TJC's definition of a sentinel event, and the Chief, Quality Management informs the executive leaders of immediate actions taken to prevent future adverse events and the type of investigation that will occur. For institutional disclosures, the Chief of Staff and ADPCS/NE said the decision is shared between the executive team and quality management staff, and the Risk Manager coordinates the process.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[26] Adverse events and close calls are assigned a safety assessment code score based on the severity of the event and how often it occurs. The safety assessment code is a "ranked matrix score (3 = highest risk, 2 = intermediate risk, 1 = lowest risk)." 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.)

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."[27] To meet this goal, VHA requires staff at its facilities to implement programs to monitor the quality of patient care and performance improvement activities and maintain TJC accreditation.[28] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from TJC).[29]

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.[30] 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."[31] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[32]

Finally, the OIG assessed the healthcare system's culture of safety.[33] 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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[27] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

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

[29] VHA Directive 1100.16.

[30] 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.

[31] VHA Directive 1190.

[32] VHA Directive 1190.

[33] 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

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."[34] The OIG did not find evidence the Peer Review Committee consistently recommended improvement actions for Level 3 peer reviews conducted from February 2021 through January 2022.[35] Failure to recommend actions likely prevented improvement in the providers' patient care practices. The Risk Manager reported that the Peer Review Committee's documented assessments were intended to be recommendations. The Risk Manager also said that the Peer Review Committee was unclear whether it had the authority to assign recommendations to employees.

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Peer Review Committee recommends improvement actions for Level 3 peer reviews.

Healthcare system concurred.

Target date for completion: September 1, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any other areas of noncompliance. In April 2022, the Peer Review Coordinator updated the provider memo to reflect that improvement actions were "recommendations" rather than "follow up action memo" as previously recorded in the Peer Review Committee minutes. The Risk Manager will make sure the Peer Review Committee recommends improvement actions for all peer reviews assigned a final Level 3 and that the actions are documented in the Peer Review Committee's meeting minutes. The numerator is all Level 3 peer reviews with documented improvement actions, and the denominator is the total number of Level 3 peer reviews completed each month. The Risk Manager will track and monitor Level 3 peer reviews for recommended improvement actions monthly and report the compliance rate to the Medical Executive Council, chaired by the Chief of Staff, until 90 percent or higher compliance is met and sustained for six consecutive months.

VHA requires staff to conduct an individual root cause analysis for all patient safety events that receive an actual or potential safety assessment code score of 3.[36] The OIG requested patient

[34] VHA Directive 1190.

[35] A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently." VHA Directive 1190.

[36] A root cause analysis is a focused review to identify the actual system- and process-related contributing factors of the event. VHA Handbook 1050.01; VHA Directive 1050.01.

safety events that were assigned an actual or potential safety assessment code score of 3 and a list of completed root cause analyses that occurred from February 2021 through January 2022. The OIG found that staff did not consistently complete individual root cause analyses for the events. When an adverse patient safety event is not thoroughly reviewed, leaders may be unable to identify system vulnerabilities that could lead to patient harm. Patient safety staff identified discrepancies in how they assigned safety assessment code scores after the OIG sought the reasons staff did not conduct root cause analyses.

Recommendation 2

2. The Director evaluates and determines any additional reasons for noncompliance and ensures staff conduct a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: The Director reviewed the recommendation and did not determine additional reasons for noncompliance. In April 2022, the Chief of Quality Management reviewed the Joint Patient Safety Reporting safety assessment coding process with the Patient Safety Managers. The Chief of Quality Management will track monthly patient safety events that received an actual or potential safety assessment code of 3, and that those events received an individual root cause analysis or were included in an aggregated review. The numerator is the number of patient safety events with an actual or potential safety assessment code of 3 that had an individual or aggregate root cause analysis. The denominator is the total number of monthly patient safety events with an actual or potential safety assessment code score of 3. The Patient Safety Manager will report the compliance rate monthly to the Quality Executive Council, chaired by the Director, until 90 percent or higher compliance is met and sustained for six consecutive months.

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."[37] 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."[38]

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.[39] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[40]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges. 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.[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

[37] 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.)

[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 30 medical staff members who had an FPPE or Ongoing Professional Practice Evaluation.

Medical Staff Privileging Findings and Recommendations

VHA states the FPPE is a defined period during which the service chief "evaluates and determines the LIP's professional performance."[44] The OIG found that FPPEs did not consistently include clearly defined time frames. If the FPPE was not time-limited, it may have led to an indefinite evaluation period. The Deputy Chief of Staff reported that section or service chiefs provided verbal notification of the FPPE time frames to the LIPs but did not document it. The deputy chief could not provide reasons for the lack of documentation.

Recommendation 3

3. The Chief of Staff evaluates and determines reasons for noncompliance and ensures section or service chiefs define time frames for Focused Professional Practice Evaluations.

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: The Chief of Staff evaluated and determined no reason for noncompliance. VA Greater Los Angeles Healthcare System implemented standardized Focused Professional Practice Evaluations forms from October through December 2022. To determine level of compliance, the Credentialing and Privileging Manager will conduct a monthly review of all completed Focused Professional Practice Evaluations and validate that a defined time frame is documented. The numerator is the number of completed Focused Professional Practice Evaluations with defined time frames each month. The denominator is the total number of completed monthly Focused Professional Practice Evaluations. The Credentialing and Privileging Manager will report the monthly compliance rate to the Medical Executive Council, chaired by the Chief of Staff, until 90 percent or higher compliance is achieved and maintained for six consecutive months.

[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 Handbook 1100.19; VHA Directive 1100.21(1).

VHA requires service chiefs to include service-specific criteria in LIPs' Ongoing Professional Practice Evaluations.[45] The OIG found that service chiefs did not consistently include service-specific criteria in Ongoing Professional Practice Evaluations. This may have led to incomplete data to support the decision to continue the LIPs' clinical privileges. The Deputy Chief of Staff could not provide reasons for the noncompliance.

Recommendation 4

4. The Chief of Staff determines the reasons for noncompliance and ensures service chiefs include service-specific criteria in Ongoing Professional Practice Evaluations.

Healthcare system concurred.

Target date for completion: June 30, 2024

Healthcare system response: The Chief of Staff evaluated and determined no reason for noncompliance. The VA Greater Los Angeles Healthcare System began to incorporate the required clinical indicators which includes service/specialty-specific criteria into the Focused and Ongoing Professional Practice Evaluation forms in March 2022. Full implementation is expected by December 31, 2023. The Credentialing and Privileging Manager will track and monitor all completed ongoing professional practice evaluations monthly. The numerator is the number of completed ongoing professional practice evaluation forms that include service/specialty-specific criteria. The denominator is the number of completed ongoing professional practice evaluations each month. The Credentialing and Privileging Manager will report the monthly compliance rate to the Medical Executive Council, chaired by the Chief of Staff, until 90 percent or higher compliance is achieved and maintained for six consecutive months.

VHA requires an executive committee of the medical staff to review professional practice evaluation results when making initial or reprivileging decisions and document its recommendation in meeting minutes.[46] The OIG reviewed Medical Executive Council meeting minutes and found the council did not consistently document its discussions and recommendations for LIPs' privileging requests.[47] This could have led to incomplete evidence for the council to recommend granting or continuing clinical privileges and could adversely affect quality of care and patient safety. The Deputy Chief of Staff reported that credentialing and privileging staffing shortages contributed to the noncompliance.

[45] VHA Handbook 1100.19; VHA Directive 1100.21(1). For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

[46] VHA Handbook 1100.19; VHA Directive 1100.21(1).

[47] This system's executive committee of the medical staff is the Medical Executive Council.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures Medical Executive Council meeting minutes consistently contain its recommendations for privileging requests.

Healthcare system concurred.

Target date for completion: February 28, 2024

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. Applications for new and continued privileges must be reviewed by the Credentialing & Privileging Committee to identify standard of care concerns and referred to the Medical Executive Council for review and recommendations to the Director. Minutes of the Credentialing and Privileging Committee will be distributed to Medical Executive Council for electronic vote by council members. The Credentialing and Privileging Manager will track, review, and monitor all completed focused and ongoing professional practice evaluations and ensure results are discussed in the Medical Executive Council meeting minutes. The numerator is the number of focused and ongoing professional practice evaluation results presented and documented at the Medical Executive Council minutes. The denominator is the total number of completed focused and ongoing practice evaluations submitted for approval each month. The Credentialing and Privileging Manager will report the monthly compliance rate to the Quality Executive Council, co-chaired by the Director, until 90 percent or higher compliance is met and maintained for six consecutive months.

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.[48] 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.[49]

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.[50] 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.[51]

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

[48] 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.)

[49] 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.

[50] 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.

[51] 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.

- West Los Angeles VA Medical Center
  - Community living center (dementia)
  - Emergency Department
  - Infusion clinic
  - Intensive care units (Pods A and B)
  - Medical/surgical inpatient units
  - Mental health inpatient unit
  - Outpatient dialysis
  - Post-anesthesia care unit
  - Specialty clinic (4 West)
  - Women's clinic
- Sepulveda Ambulatory Care Center
  - Community living center (G35 and G63)
  - Geriatric clinic
  - Primary care clinic (green team)
  - Women's clinic
- Los Angeles Ambulatory Care Center
  - Dental clinic
  - Ear, nose, and throat clinic
  - Primary care clinic
  - Specialty clinic

Environment of Care Findings and Recommendations

TJC requires that staff at "the hospital inspects, tests, and maintains medical equipment."[52] The OIG found expired preventive maintenance stickers on medical equipment in multiple clinical areas.[53] When staff do not inspect, test, and maintain medical equipment, it could malfunction or

[52] TJC, *Standards Manual*, EC.02.04.03, January 1, 2022.

[53] Deficient areas with expired preventive maintenance stickers on medical equipment included the Sepulveda Ambulatory Care Center (women's clinic – an electrosurgical device and two light sources), Los Angeles Ambulatory Care Center (Dental - x-ray machine and Ear, Nose, and Throat - flex scope), and West Los Angeles VA Medical Center (women's clinic - electrocardiograph).

produce incorrect readings, which may result in patient harm. The Chief Nurse Ambulatory Care reported that one of the medical devices with an expired sticker was no longer in use, and staff could not provide a reason for noncompliance for the remaining devices.

Recommendation 6

6. The Associate Director, Operations evaluates and determines any additional reasons for noncompliance and ensures staff inspect, test, and maintain all medical equipment.

Healthcare system concurred.

Target date for completion: September 1, 2023

Healthcare system response: The Associate Director, Operations reviewed the recommendation and identified no additional reasons for noncompliance. The numerator is completed preventive maintenance equipment checks performed each month, and the denominator is scheduled preventive maintenance checks due each month. Biomedical Engineering staff tracks preventive maintenance monthly. Biomedical Engineering staff have tracked preventive maintenance completion rates from July through December 2022 with greater than 90 percent compliance. The Chief of Biomedical Engineering or designee reports the numerator and denominator compliance data quarterly to the Environment of Care Council, chaired by Associate Director, Operations.

TJC requires staff to keep areas used by patients clean, safe, and suitable for care and maintain equipment and furnishings in good working order.[54] The OIG found various deficiencies including rusty sinks, dirty floors and equipment, damaged walls and furniture, and stained ceiling tiles.[55] These deficiencies create a potential risk of infection to both patients and staff. Leaders reported various contributing factors for noncompliance including staffing shortages and limited funds. Failure to maintain a clean and safe environment is a repeat finding from the 2019 comprehensive healthcare inspection.[56]

Recommendation 7

7. The Director evaluates and determines any additional reasons for noncompliance and ensures staff maintain equipment and furnishings in good working order and keep areas used by patients clean, safe, and suitable for care.

[54] TJC, *Standards Manual*, EC.02.06.01, January 1, 2022.

[55] The OIG found these issues at the Sepulveda and Los Angeles Ambulatory Care Centers and the West Los Angeles VA Medical Center.

[56] VA OIG, *Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System, California*, Report No. 18-04671-25, December 2, 2019.

Healthcare system concurred.

Target date for completion: January 18, 2024

Healthcare system response: The Director reviewed the recommendation and determined no additional reasons for noncompliance. The Occupational Safety & Health Specialist will conduct monthly audits to determine compliance to identify deficiencies not closed within two weeks as required. The numerator is the number of outstanding Performance Logic findings resolved within two weeks. The denominator is the total number of Performance Logic findings each month. The Occupational Safety & Health Specialist or designee will report monthly audit compliance to the Environment of Care Council, chaired by the Associate Director, Operations until 90 percent or greater compliance is met and maintained for six consecutive months.

The Mental Health Environment of Care Checklist criteria indicate that shower curtains be "made of breathable material (not plastic or vinyl) so that they cannot be used for suffocation."[57] The OIG found a plastic shower curtain in the bathroom for the seclusion room in the mental health inpatient unit. When plastic shower curtains are left unsecured, there is an increased risk for patients' self-harm or harm to others. The Chief, Quality Management reported believing the shower curtain was vinyl and not a suffocation risk.

Recommendation 8

8. The Director evaluates and determines reasons for noncompliance and ensures that only breathable shower curtains are present in mental health inpatient unit bathrooms.

[57] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," September 30, 2020.

Healthcare system concurred.

Target date for completion: January 15, 2024

Healthcare system response: The Director reviewed the recommendation and did not determine additional reasons for noncompliance. Environmental Management Services removed the vinyl breakaway curtains from the seclusion rooms on the Inpatient Mental Health Unit (2 West) at the time of the OIG inspection visit. There were no safety events associated with vinyl shower curtain usage and they remain up in shared rooms for patient privacy. The healthcare system's Interior Design staff is in the process of identifying and purchasing approved mental health shower curtains or alternate barriers for the remaining 12 of 17 bathrooms on the Inpatient Mental Health Unit. The numerator is number of Inpatient Mental Health Unit bathrooms with installed approved shower curtains or alternate barriers. The denominator is the total number of Inpatient Mental Health Unit bathrooms. Environmental Management Service staff will monitor and report the compliance rate monthly to the Environment of Care Council, chaired by the Associate Director, Operations, until 90 percent or greater compliance is met and maintained for six consecutive months.

VHA requires "video or audio monitoring equipment installed for patient safety purposes only [be] accessed and viewed by VA health care providers, who are responsible for ensuring the safe delivery of care and authorized to take action based on the monitoring accessed" and "equipment is used to monitor (rather than record) the patient."[58] The OIG noted the West Los Angeles VA Medical Center mental health inpatient unit had cameras throughout the area that recorded video. When cameras used for patient safety purposes also record, the information may be viewed by unauthorized personnel, leading to violation of the patients' right to consent to video recording. The Chief of Police reported that nursing staff monitor the cameras but do not have access to the recordings. The Nurse Manager, Inpatient Mental Health reported that cameras were used for patient safety monitoring but admitted to requesting and obtaining a recording of a patient incident from VA police.

Recommendation 9

9. The Chief of Staff or Associate Director, Patient Care Service/Nurse Executive determines the reasons for noncompliance and ensures video or audio monitoring equipment installed for patient safety purposes does not record and is only accessed and viewed by Veterans Affairs healthcare providers.

[58] VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021.

Healthcare system concurred.

Target date for completion: February 28, 2024

Healthcare system response: The Associate Director of Operations reviewed the recommendation and did not identify a reason for noncompliance. Cameras, including those in the Inpatient Mental Health Unit (2 West) are only located in common areas, such as waiting areas, courtyards, and hallways. Campus wide signage indicates that individuals entering the facility are subject to recording, and inpatient[s] subject to surveillance. On June 30, 2023, the engineering staff secured the monitoring equipment room and deactivated the recording. The numerator is the number of days the camera's video recording capability in the Inpatient Mental Health Unit remains deactivated. The denominator is the number of days in the month. Engineering staff will conduct random monitoring for recording compliance one day each month until 100 percent compliance rate is met then conduct random audits for six consecutive months for sustainment. Engineering staff will report compliance rates at the Environment of Care Council, chaired by the Associate Director, Operations, monthly.

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."[59] 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."[60]

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.[61] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in the Emergency Department or urgent care center 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."[62] 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 49 randomly selected patients who were seen in the Emergency Department or urgent care center from December 31, 2020, through August 1, 2021.

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

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

[61] 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.)

[62] 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

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 nine 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 nine OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, ADPCS/NE, and Associate Director, Operations. 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 Peer Review Committee recommends improvement actions for Level 3 peer reviews. • Staff conduct a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.
Medical Staff Privileging	• Section or service chiefs define time frames for Focused Professional Practice Evaluations. • Service chiefs include service-specific criteria in Ongoing Professional Practice Evaluations. • Medical Executive Council meeting minutes consistently contain its recommendations for privileging requests.
Environment of Care	• Staff inspect, test, and maintain all medical equipment. • Staff maintain equipment and furnishings in good working order and keep areas used by patients clean, safe, and suitable for care. • Only breathable shower curtains are present in mental health inpatient unit bathrooms. • Video or audio monitoring equipment installed for patient safety purposes does not record and is only accessed and viewed by Veterans Affairs healthcare providers.
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 highest complexity (1a) affiliated healthcare system reporting to VISN 22.[1]

Table B.1. Profile for VA Greater Los Angeles Healthcare System (691) (October 1, 2018, through September 30, 2021)

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Total medical care budget	$1,078,136,969	$1,224,147,279	$1,424,653,901
Number of:			
• Unique patients	87,172	85,778	90,043
• Outpatient visits	1,315,373	1,186,648	1,340,945
• Unique employees§	4,165	4,444	4,664
Type and number of operating beds:			
• Community living center	372	372	372
• Domiciliary	296	296	296
• Medicine	104	104	104
• Mental health	105	105	105
• Neurology	10	10	10
• Rehabilitation medicine	25	25	25
• Surgery	46	46	46
Average daily census:			
• Community living center	244	215	180
• Domiciliary	222	132	100
• Medicine	88	86	91
• Mental health	50	56	49
• Neurology	3	2	2
• Rehabilitation medicine	14	15	16

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

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Average daily census cont.			
• Surgery	19	16	15

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: July 11, 2023

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

Subj: Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System in California

To: Director, Office of Healthcare Inspections (54HF05)

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 VA Greater Los Angeles [Healthcare] System in California.
2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted action plans of the VA Greater Los Angeles 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: July 7, 2023

From: Interim Executive Director, VA Greater Los Angeles Healthcare System (691)

Subj: Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System in California

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 Greater Los Angeles Healthcare System in California. I concur with the findings and recommendations in the report.
2. The corrective actions were taken or are in progress with target dates set for the completion of the items in the attached report. VA Greater Los Angeles Healthcare System remains committed to ensuring a safe environment of care where Veterans can receive the exceptional health care they deserve.

(Original signed by:)

Robert C. Merchant

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