US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Palo Alto Health Care System in California

CHIP Report	22-00064-172	August 9, 2023

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Figure 1. *Palo Alto VA Medical Center of the VA Palo Alto Health Care System in California.*

Source: https://www.va.gov/palo-alto-health-care/.

Abbreviations

ADPCS	Associate Director for Patient Care Services/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 Palo Alto Health Care System, which includes medical centers in Palo Alto, Menlo Park, and Livermore and multiple outpatient clinics in 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 Palo Alto Health Care System during the week of May 9, 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 in 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 four recommendations to the System Director and Chief of Staff in the following areas of review: Leadership and Organizational Risks and Environment of Care. These results are detailed throughout the report and summarized in appendix A on page 24.

Conclusion

The OIG issued four recommendations for improvement to the System Director and Chief of Staff. 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 Executive Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 27–28, and the responses within the body of the report for the full text of the directors' comments). The OIG 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 Palo Alto 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 VA Palo Alto Health Care System provides care through its three medical centers, located in Palo Alto, Menlo Park, and Livermore, and associated outpatient clinics in California. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from March 5, 2018, through May 12, 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 Palo Alto Health Care System occurred in March 2018. The Joint Commission performed hospital, behavioral health, and home care accreditation reviews in February 2019. System staff reported undergoing a Joint Commission triennial survey on April 26, 2022 (two weeks prior to the CHIP visit), but leaders did not have survey results to provide to the OIG.

[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 an executive leadership team consisting of the System Director, Deputy Director, Chief of Staff, and Associate Director for Patient Care Services/Nurse Executive (ADPCS). The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive leadership team had worked together for more than five months with the addition of the Deputy Director in November 2021. The ADPCS had served in the role since July 2020, but an Acting ADPCS had been assigned to the role in September 2021, when the permanent ADPCS was detailed to another position. To help assess the executive leaders' engagement, the OIG interviewed the System Director, Deputy Director, Chief of Staff, and Acting ADPCS regarding their knowledge, involvement, and support of actions to improve or sustain performance.

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[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[8] Swensen 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.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $1,346,105,824 had increased by approximately 8 percent compared to the previous year's budget of $1,251,290,534.[10] The System Director described Palo Alto, California as the most expensive place to live in the United States and explained how competitive it was to recruit staff due to higher community salaries. The Deputy Director reported that leaders spent $37,000,000 on nurse retention during the COVID-19 pandemic. The Deputy Director also reported the equipment budget increased from $5,000,000 to $20,000,000 due to equipment nearing the time frame for end of use.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

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

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

The OIG reviewed results from VA's All Employee Survey from FYs 2019 to 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[12]

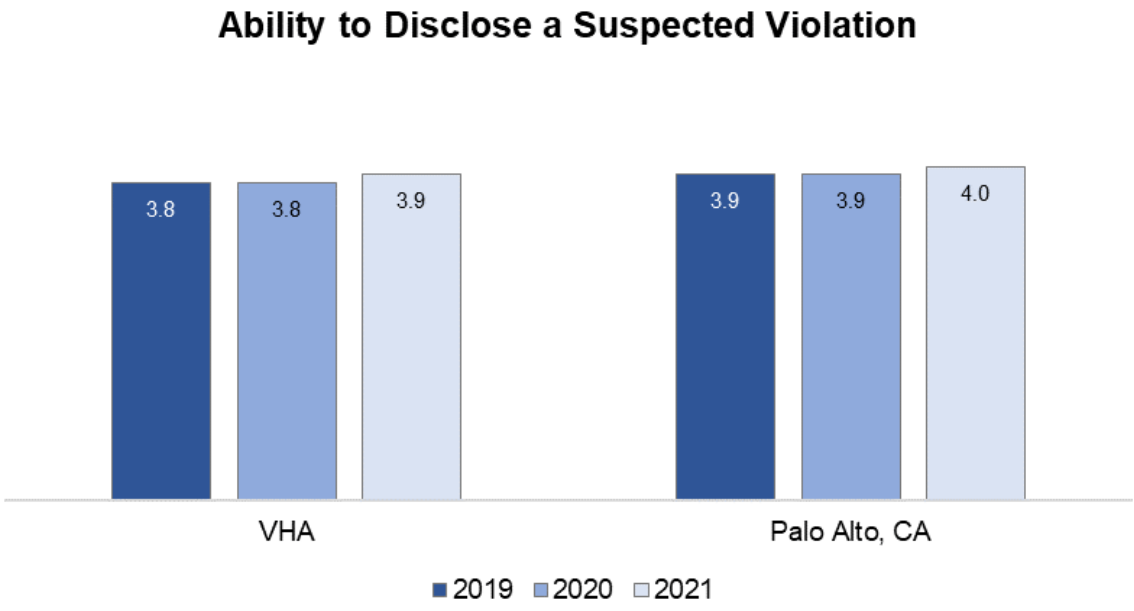

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed April 5, 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.[13]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare

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

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

[14] "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.[15]

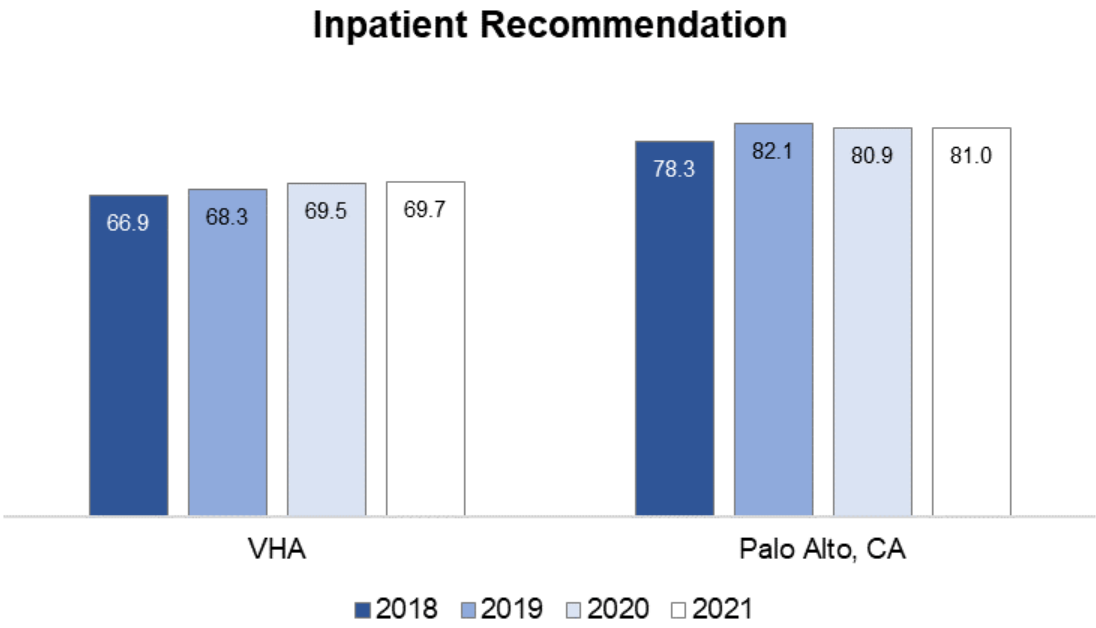

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

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

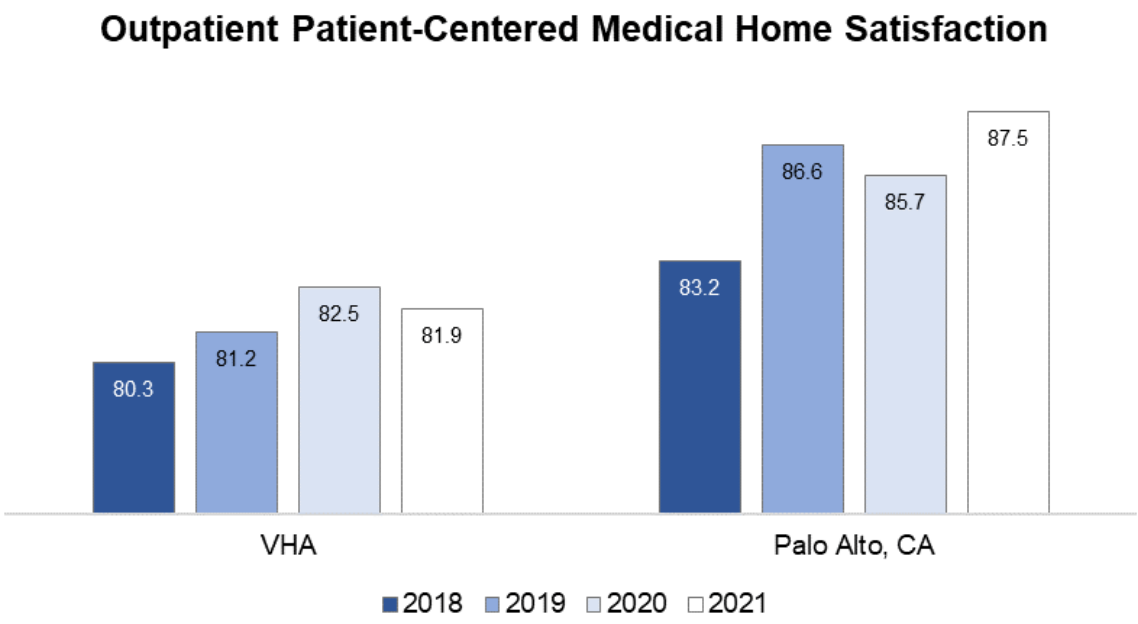

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

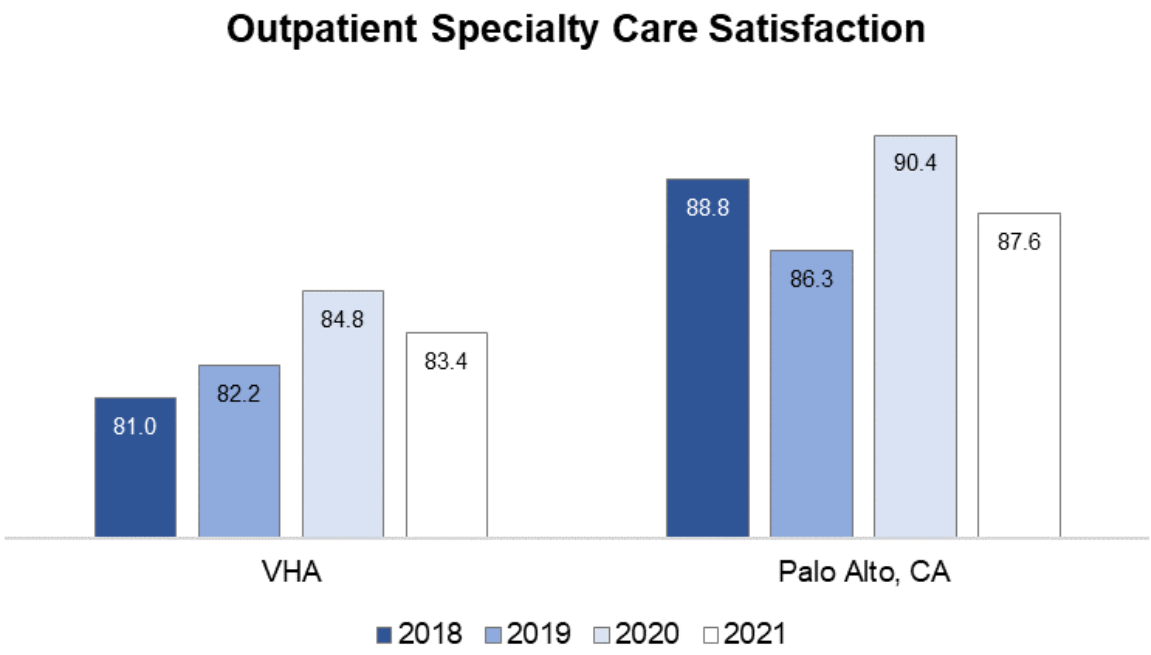

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.[16] "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)."[17] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and

[16] 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/.

[17] The Joint Commission (TJC), *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates TJC's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

recourse."[18] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[19] To this end, VHA implemented 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.[20] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[21] System leaders were able to describe the adverse event reporting process; however, the OIG reviewed sentinel event and institutional disclosure processes and identified a vulnerability with leaders disclosing events.

Leadership and Organizational Risks Findings and Recommendations

VHA requires leaders to conduct an institutional disclosure when an adverse event causes or may cause the patient's death or serious injury.[22] The OIG requested adverse patient safety events and reviewed the events reported by healthcare system staff. The OIG identified that leaders did not consistently conduct institutional disclosures for sentinel events that may have contributed to patients' deaths. Failure to conduct institutional disclosures may reduce patients' trust in the organization. The Patient Safety Manager reported not serving in the role when the sentinel events occurred and lacking knowledge about the prior process.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures leaders conduct institutional disclosures for all applicable sentinel events.

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

[19] VHA Directive 1004.08.

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

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

[22] VHA Directive 1004.08.

Healthcare system concurred.

Target date for completion: January 31, 2024

Healthcare system response: In collaboration with the Chief of Staff, the System Director determined there were no additional reasons for noncompliance.

The Patient Safety and Risk Programs meet weekly to share information driven by patient safety events. All sentinel events will be tracked by the Patient Safety Program through the National Center for Patient Safety database and documented in a local tracking tool to ensure that institutional disclosures are completed as required.

The Risk Management department will compare institutional disclosures to sentinel events and monitor until a 90% compliance is achieved for two consecutive quarters. The compliance data will be reported quarterly to the Medical Executive Council.

Quality, Safety, and Value

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

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system's committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

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

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

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

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

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

[25] VHA Directive 1100.16.

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

[27] VHA Directive 1190.

[28] VHA Directive 1190.

[29] A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organizations health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, accessed October 13, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospitalusersguide.pdf.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[30] 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."[31]

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.[32] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[33]

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."[34] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[35] 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.[36]

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.[37] 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

[30] 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.)

[31] VHA Handbook 1100.19.

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[38]

The OIG interviewed key managers 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

VHA requires "the criteria for the FPPE process…to be defined in advance, using objective criteria accepted by the practitioner."[39] The OIG found that nine LIPs' folders lacked evidence they were aware of and had accepted the evaluation criteria before service chiefs initiated the FPPE process. When practitioners are not informed of the evaluation criteria, they may not understand FPPE expectations. The Chief of Staff reported that service chiefs had verbal conversations with newly hired providers 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.

[38] 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.

[39] 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.[40] 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.[41]

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.[42] 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.[43]

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

- Palo Alto VA Medical Center

[40] 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.)

[41] 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.

[42] 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.

[43] 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
  - Inpatient mental health (520B Birch)
  - Medical Intensive Care Unit
  - Medical/surgical unit (3C Med/Surg)
  - Short stay and hospice (4C)
  - Women's Health Clinic
- Palo Alto VA Medical Center–Menlo Park
  - Community Living Center (CLC 331B)
  - Dental Clinic
- Palo Alto VA Medical Center–Livermore
  - Community Living Center (CLC-B)
  - Patient aligned care team (General Medicine Clinic)
  - Same Day Clinic

Environment of Care Findings and Recommendations

The OIG identified deficiencies with medical equipment preventive maintenance, medication storage, and environmental cleanliness. Additionally, the OIG reviewed the Mental Health Environment of Care Checklist for July 2021 and January 2022 and noted the same deficiencies on both reports, at least one of which—plastic can liners in the dining room—could be easily rectified.

VHA requires facility directors to comply with TJC requirements "for maintaining, inspecting, and testing all medical equipment," which includes specifying activities and frequencies in writing.[44] In six patient care areas inspected, the OIG observed portable medical equipment for which preventive maintenance had exceeded the healthcare system's frequency of one year.[45] Equipment that is not properly maintained poses potential harm to patients, visitors, and staff. The Chief of Biomedical Engineering stated the equipment maintenance program was large and the portability of some equipment made tracking difficult, also admitting there was no specific schedule for reviewing portable equipment. The Chief of Engineering cited staffing challenges as

[44] VHA Directive 1100.16; TJC, *Standards Manual*, E-dition, EC 02.04.01, January 2020; VHA Directive 1860, *Biomedical Engineering Performance Monitoring and Improvement*, March 22, 2019.

[45] The six units with medical equipment without annual preventive maintenance were the Emergency Department, Medical Intensive Care Unit, 3C Med/Surg, 4C, CLC 331B, and CLC-B.

another contributing factor, adding that the biomedical engineering department had 15 full-time employees and five vacant positions.

Recommendation 2

2. The System Director determines any additional reasons for noncompliance and ensures staff conduct required preventive maintenance on medical equipment.

Healthcare system concurred.

Target date for completion: March 31, 2024

Healthcare system response: In collaboration with the Associate Director, the System Director reviewed the recommendation and determined there were no additional reasons for noncompliance.

The Biomedical Engineering department has scheduled multidisciplinary rounds to begin August 2023. These rounds will be conducted throughout all clinical areas in the facility bi-annually to identify medical devices due for preventative maintenance prior to their re-inspection date and occur opposite and in addition to the facility environment of care rounds. The Biomedical Engineering department will begin using a new computer maintenance management system on August 26, 2023, to track, monitor, and document preventative maintenance on all medical equipment throughout and the healthcare system. The automated system pulls in all medical devices by serial number, allows the review of the last date of preventative maintenance and generate reports for upcoming preventative maintenance. This system will also be used for turn-in/hard-drive removal of medical devices, update utilization information on medical devices for triggering preventative maintenance, confirming that clinical staff also could locate medical devices using approval workflow, scheduling preventative maintenance for medical equipment in use on patients, and enhanced reporting and analytics to help make data informed decisions on medical devices. The Veteran Health Affairs Planned Maintenance Program Health Technology Maintenance (HTM) Service Bulletin titled SB2017-002 dated April 2017, defines the term "completed as scheduled" and timeframes for preventative maintenance depending on the device manufacture instructions for use. The new computer maintenance management program will be used to measure compliance by the total number of medical devices that have their preventative maintenance completed as scheduled as defined by the HTM service bulletin. The numerator will measure the total number of medical devices that have their preventative maintenance completed as scheduled and the denominator will be the total number of all medical devices that require preventative maintenance. Compliance will be reported until 90% compliance is sustained for two consecutive quarters. Compliance will be reported monthly to the Quality Executive Council and quarterly to the Environment of Care Council (EOCC).

VHA requires that "medications are stored in a secure manner…[and] access…is limited to authorized personnel who dispense or administer medication."[46] For two of the medication rooms inspected, the OIG observed an unauthorized staff member accessing one room and was informed that unauthorized staff had access to the other room, which contained an automated dispensing cabinet and sterile and commercial supplies. This could potentially allow unauthorized access to medications. The OIG notified the Chief of Pharmacy that unauthorized personnel had access to medications.

Recommendation 3

3. The Chief of Staff determines the reasons for noncompliance and ensures only authorized staff have access to medications.

Healthcare system concurred.

Target date for completion: January 31, 2024

Healthcare system response: In collaboration with the Chief of Staff and the Associate Director for Patient Care Services, the System Director determined there were no additional reasons for noncompliance.

The facility took several actions to immediately improve medication security and access. The Engineering Service updated the codes to all medication rooms to prevent unauthorized access. The Quality, Safety, and Value service scheduled rounds which began July 2023 to ensure only authorized staff have access to medication, which track specific indicators related to medication room access and medication storage. These rounds will be conducted quarterly in all clinical areas. Each indicator will be monitored and reported until a 90% compliance is sustained for two consecutive quarters. Compliance will be reported monthly to the Quality Executive Council and quarterly to the Environment of Care Council.

VHA and TJC require leaders at hospitals to maintain a clean and safe environment.[47] For the areas inspected, the OIG observed ice and water dispensing machines with dirty tubes at the dispensing end; storage racks missing solid liners on the bottom shelves; damage to and holes in walls; dirty, stained, or missing ceiling tiles; and corrugated boxes in patient care or clean

[46] VHA Directive 1108.06(2), *Inpatient Pharmacy Services*, February 8, 2017, amended August 26, 2021. (VHA rescinded and replaced this directive with VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022. The two directives contain similar language related to securing medications and limiting access.)

[47] VHA Directive 1100.16; VHA Directive 1608; TJC, *Standards Manual*, E-dition, EC.02.06.01, January 2020. "The hospital establishes and maintains a safe, functional environment." VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

storage areas.[48] An unsafe or unclean clinical environment could cause patients, visitors, and staff to become injured or ill.

The Chief of Engineering indicated that engineering staff cleaned the inside of ice and water dispenser panels; however, they were unsure how to clean the water dispensing tubes. As noted previously, the Chief of Engineering reported that staffing challenges made it difficult to maintain clean environments. The Chief of Engineering further reported that ceiling tiles were on back order, so leaders had purchased as many as possible locally, which they were using to replace any broken or stained tiles.

Recommendation 4

4. The System Director determines any additional reasons for noncompliance and ensures leaders maintain a clean and safe environment.

[48] The units identified were the Emergency Department, 520B Birch, Medical Intensive Care Unit, 3C Med/Surg, 4C, Women's Health Clinic, CLC 331B, Dental Clinic, CLC-B, and General Medicine Clinic. For ice and water machines with dirty dispensing tubes: Medical Intensive Care Unit, 3C Med/Surg, CLC 331B, and CLC-B. For storage racks missing bottom liner: 520B Birch, CLC 331B, Dental Clinic, and CLC-B. For walls with damage and holes: the Emergency Department, 520B Birch, Medical Intensive Care Unit, 3C Med/Surg, 4C, Women's Health Clinic, CLC 331B, and CLC-B. For ceiling tiles: 4C, Palo Alto main lobby, Emergency Department, and lobby common areas. For corrugated boxes: the Emergency Department, 520B Birch, and 4C. Corrugated boxes are an infection control concern because they can house pests, droppings, and larva, which can later become an infestation. VHA Directive 1761.

Healthcare system concurred.

Target date for completion: January 31, 2024

Healthcare system response: In collaboration with the Associate Director and Associate Director for Patient Care Services, the System Director reviewed the recommendation and determined there were no additional reasons for noncompliance. The Associate Director in collaboration with the Associate Director for Patient Care Services will ensure staff maintain a safe and clean environment.

Engineering Service in collaboration with Environmental Management Services inspected and cleaned ice machines at time of survey and continue to ensure the ice machines are cleaned and serviced. Additionally, ice machines are inspected monthly by the Environmental Management Service area supervisors. Environmental Management Services corrected dusty ceiling tiles at the time of survey. Cleanliness of ceiling tiles are inspected monthly. Engineering Service continues to work throughout the facility systematically patching and painting. The Logistics Service completed a facility review to ensure clean supply rooms contained solid liners on the bottom shelves and initiated orders for covers that were not covering the bottom shelf fully.

The Quality, Safety, and Value service scheduled rounds which began July 2023 to monitor the cleanliness related to each specific finding. These rounds will track specific indicators related to ice machines, ceiling tiles, cardboard, storage room liners, paint, and penetrations. These rounds will be conducted quarterly in all clinical areas. Each indicator will be monitored and reported until a 90% compliance is sustained for two consecutive quarters. Compliance will be reported monthly to the Quality Executive Council and quarterly to the Environment of Care Council (EOCC).

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."[49] 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."[50]

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.[51] 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."[52] 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 staff and managers and reviewed the electronic health records of 50 randomly selected patients who were seen in the Emergency Department from December 31, 2020, through August 1, 2021.

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

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

[51] 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.)

[52] 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 four 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 four OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the System Director and Chief of Staff. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• Leaders conduct institutional disclosures for all applicable sentinel events.
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• Staff conduct required preventive maintenance on medical equipment. • Only authorized staff have access to medications. • Leaders maintain a clean and safe environment.
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 21.[1]

Table B.1. Profile for VA Palo Alto Health Care System (640) (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	$1,066,677,940	$1,251,290,534	$1,346,105,824
Number of:			
• Unique patients	65,446	63,425	68,170
• Outpatient visits	790,232	734,542	873,296
• Unique employees§	4,404	4,717	4,840
Type and number of operating beds:			
• Blind rehabilitation	27	27	27
• Community living center	360	360	360
• Domiciliary	172	172	172
• Medicine	67	67	67
• Mental health	40	40	40
• Rehabilitation medicine	30	30	30
• Residential rehabilitation	10	10	10
• Spinal cord	43	43	31
• Surgery	42	42	42
Average daily census:			
• Blind rehabilitation	13	5	5
• Community living center	220	233	186
• Domiciliary	103	72	32
• Medicine	43	40	43
• Mental health	29	24	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." "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‡
• Rehabilitation medicine	14	18	17
• Residential rehabilitation	7	6	1
• Spinal cord	19	20	18
• Surgery	25	20	18

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 19, 2023

From: Director, VA Sierra Pacific Network (10N21)

Subj: Comprehensive Healthcare Inspection of the VA Palo Alto Health Care System in California

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

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

1. Thank you for the opportunity to respond to the draft report, Comprehensive Healthcare Inspection of the VA Palo Alto Health Care System in California.
2. I have reviewed the findings and recommendations in the OIG draft report. I concur with the submitted action plans.

(Original signed by:)

Ada Clark, FACHE, MPH
Interim Network Director
VA Sierra Pacific Network (VISN 21)

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: July 19, 2023

From: Director, VA Palo Alto Health Care System (640)

Subj: Comprehensive Healthcare Inspection of the VA Palo Alto Health Care System in California

To: Director, VA Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review and respond to the OIG Draft Report: Comprehensive Healthcare Inspection of the VA Palo Alto Health Care System in California.
2. We have been actively working to address the recommendations since the conclusion of the Office of the Inspector General's (CHIP) review. We appreciate the perspective from the OIG evaluation and have taken further action to strengthen and improve our medical center processes. Implementation of the recommendations are still in progress.
3. I have reviewed the recommendations and concur with the response and action plans provided by our team here at the VA Palo Alto Health Care System to ensure we continue to deliver excellent care to our Veterans.

(Original signed by:)

Jean J. Gurga, MA, OTR/L
Executive Medical Center Director

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