US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Alexandria VA Health Care System in Pineville, Louisiana

CHIP Report | 22-00073-223 | September 29, 2023

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Figure 1. *Alexandria VA Medical Center of the Alexandria VA Health Care System in Pineville, Louisiana.*

Source: [*https://oigcrrappdmgdev.vha.med.va.gov/Draco/Draco.aspx*](https://oigcrrappdmgdev.vha.med.va.gov/Draco/Draco.aspx) (*accessed April 1, 2022*). (This website is not publicly accessible.)

Abbreviations

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

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

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

The OIG conducted an unannounced virtual inspection of the Alexandria VA Health Care System from July 11 through July 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 in several areas reviewed and issued four recommendations to the Chief of Staff in the Medical Staff Privileging and Mental Health areas of review. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 22.

Conclusion

The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 24–25, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendation 4 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Alexandria VA Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

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

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

Methodology

The Alexandria VA Health Care System includes the Alexandria VA Medical Center and associated outpatient clinics in Louisiana. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from June 19, 2017, through July 14, 2022.[5] During the virtual visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] The OIG reviews 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 Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that medical center 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 Alexandria VA Health Care System occurred in June 2017. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in April 2021 and a laboratory accreditation review in May 2021.

[6] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this healthcare system's leadership and risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. This healthcare system had a leadership team consisting of the Medical Center Director (Director), Chief of Staff, Associate Director of Patient Care Services, and Associate Director. The Chief of Staff and Associate Director of Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for more than two months, with the acting Associate Director of Patient Care Services serving in the position since May 2022. The Director had served in the role since January 2016, and the Chief of Staff and Associate Director had been in their positions since July and December 2020, respectively. To help assess the executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, acting Associate Director of Patient Care Services, and Associate Director 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 $403,662,899 had increased by approximately 13 percent compared to the previous year's budget of $357,748,327.[10] The Director stated that the budget increase allowed leaders to hire patient care staff during the COVID-19 pandemic and compete with private sector recruiting incentives. The Director also reported that some staff had returned to work at the VA healthcare system after employment with other local hospitals. The Associate Director stated that leaders used funds to purchase supplies like masks and infrastructure such as plexiglass partitions, barriers to limit campus access, and outdoor shelters to shield staff and patients in the outside vaccination clinics.

The Associate Director described the challenges of encouraging people to move to and work in Alexandria and competing for staff with community hospitals that were quicker and more flexible in increasing salaries and retention bonuses than Veterans Health Administration (VHA). The Associate Director also reported strengthening the recruiting pipeline by partnering with local colleges to establish connections for healthcare students to work at the system while in school, which assisted with the immediate personnel shortages and may provide long-term staffing continuity.

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.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal (see figure 2).[12]

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

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

[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 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).

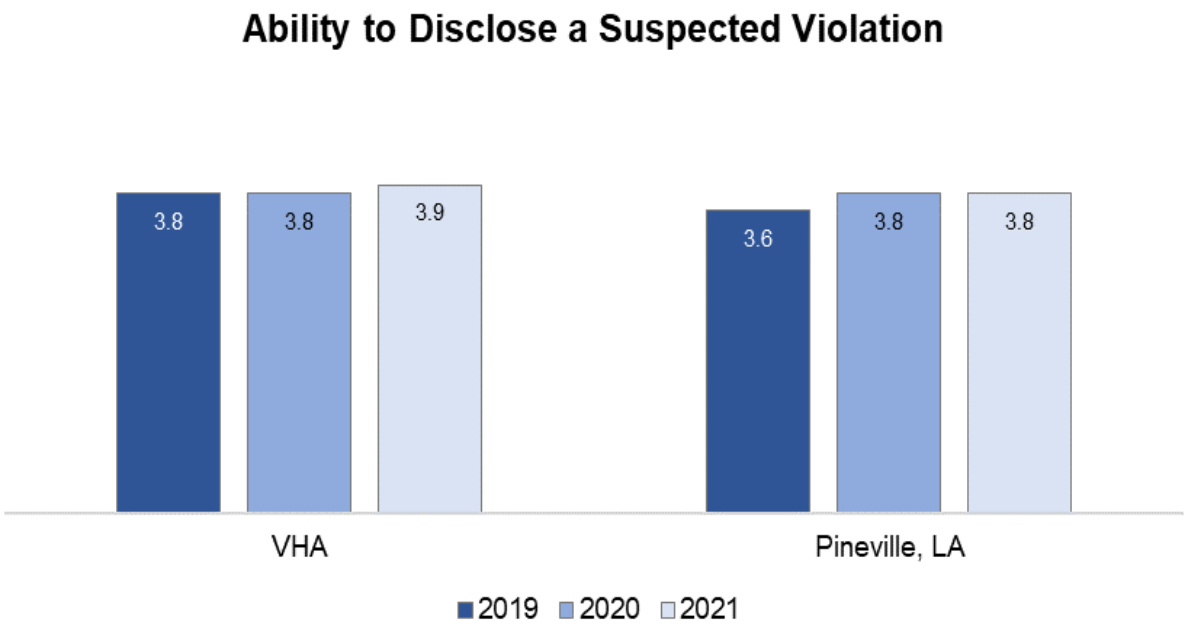

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed June 8, 2022).

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

Patient Experience

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 system from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the healthcare system over time.[15]

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

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

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

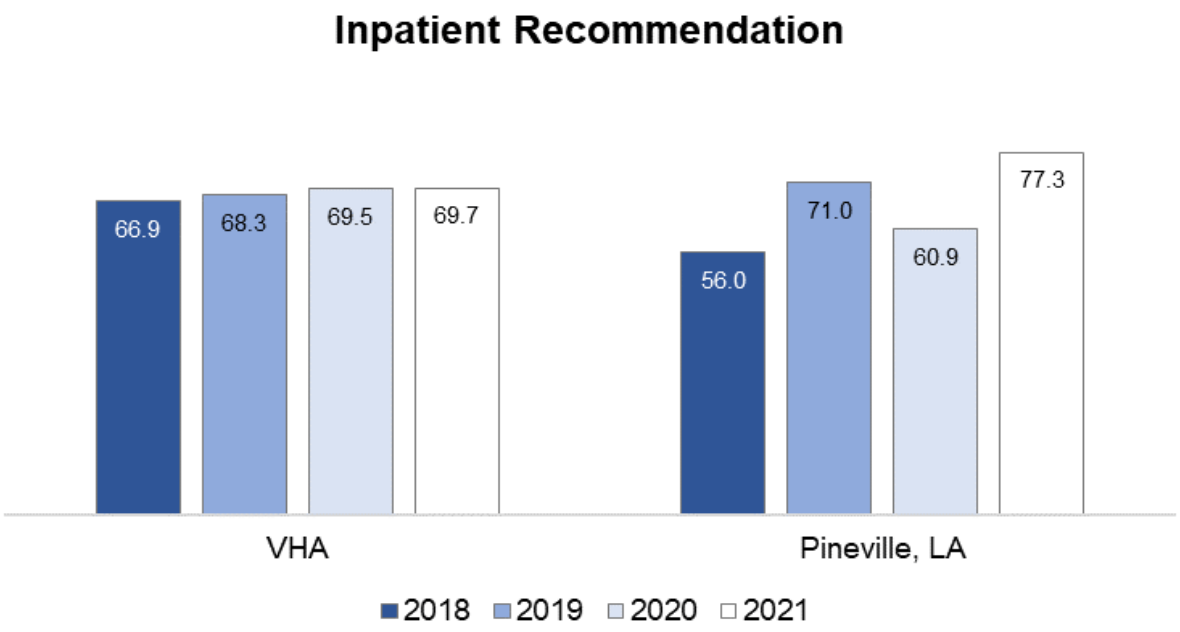

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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

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

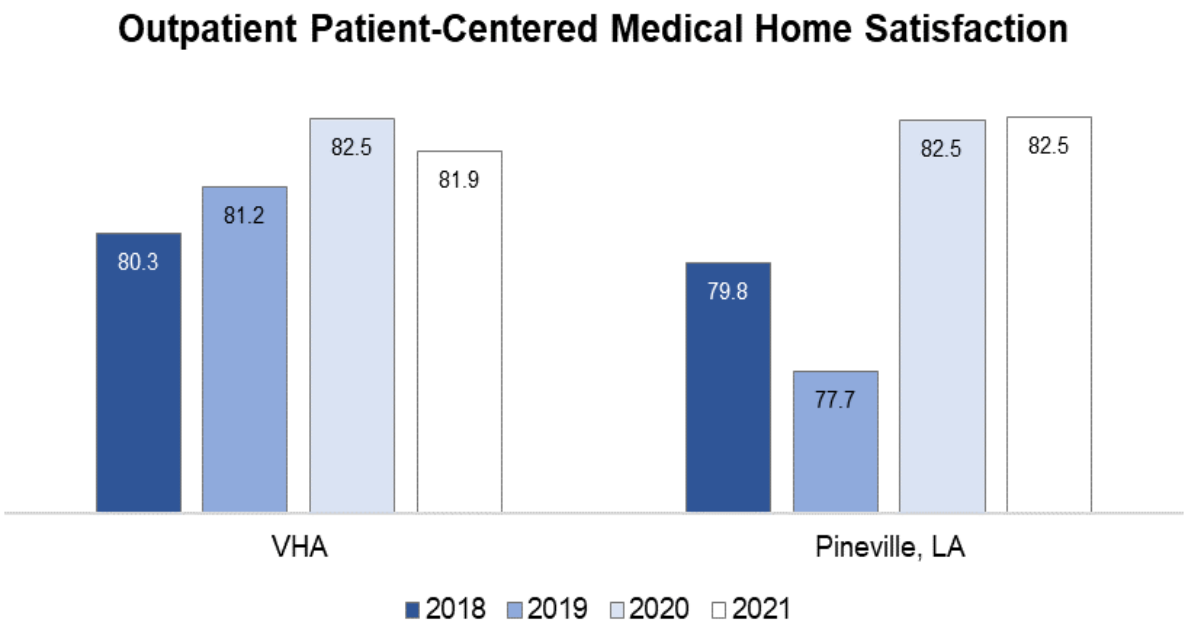

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

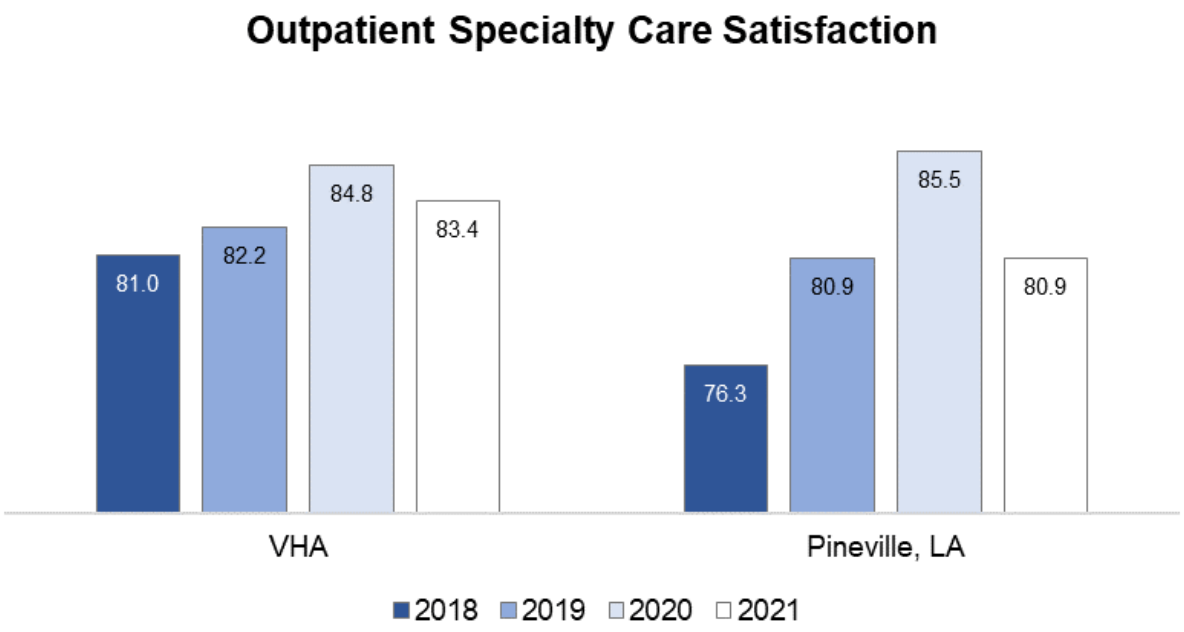

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[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, *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."[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 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]

The OIG requested adverse patient safety events that occurred since June 19, 2017, and reviewed the information staff provided. The Director explained that the Patient Safety Manager informed executive leaders immediately when a patient safety event occurred during the day and notified them in the daily morning report if any events occurred the previous evening. Additionally, the Director discussed supporting a culture of safety within the healthcare system by encouraging staff to report any safety concerns and meeting monthly with service supervisors to discuss system-wide safety issues. The Director also explained that the Chief of Staff was responsible for deciding whether to conduct a clinical or institutional disclosure and should consult with the VISN Chief Medical Officer if needed.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[19] VHA Directive 1004.08.

[20] The Joint Commission, *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.

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."[22] 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 Joint Commission accreditation.[23] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[24]

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.[25] 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."[26] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[27]

Finally, the OIG assessed the healthcare system's culture of safety.[28] 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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[22] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[23] 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.)

[24] VHA Directive 1100.16.

[25] 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.

[26] VHA Directive 1190.

[27] VHA Directive 1190.

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

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[29] 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."[30]

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

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 (OPPE) to ensure the continuous delivery of quality care.[33]

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.[34] 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

[29] 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.)

[30] VHA Handbook 1100.19.

[31] VHA Handbook 1100.19.

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[35]

The OIG interviewed key managers and reviewed the privileging folders of 33 medical staff members who had an FPPE or OPPE.

Medical Staff Privileging Findings and Recommendations

VHA requires FPPE criteria "to be defined in advance, using objective criteria accepted by the LIP."[36] The OIG reviewed privileging folders and did not find documentation that service chiefs made LIPs aware of FPPE criteria before initiating the evaluation process, which may result in LIPs misunderstanding expectations. The Chief of Staff explained that service chiefs were required to discuss FPPE expectations in advance. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

VHA also requires FPPEs to be completed for LIPs who do "not have documented evidence of competently performing the requested privileges."[37] The OIG did not find evidence service chiefs completed most FPPEs reviewed. As a result, the LIPs may have continued to deliver care without a thorough evaluation of their practices, which could have negatively affected quality of care and patient safety. The Chief of Staff attributed the deficiency to staff vacancies and lack of oversight.

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs complete Focused Professional Practice Evaluations.

[35] 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.

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

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

Healthcare system concurred.

Target date for completion: March 1, 2024

Healthcare system response: Chief of Staff evaluated and determined there were no additional reasons for noncompliance. Executive Leadership approved an additional position for a Credentialing Analyst. The Credentialing Analyst's primary responsibility will be to ensure services are compliant with Focused Professional Practice Evaluations (FPPE) processes. Additionally, Service Chiefs developed a tracking process to ensure timely completion of data collection, chart reviews, and supervisory reviews with providers. Credentialing Analyst conducted 100 percent review of all FPPE evaluations and services are at target compliance of 90 percent or greater. Audit reports will continue to be submitted to the Executive Committee of the Medical Staff which is the governance committee responsible for maintaining oversight and compliance. The facility will continue to monitor the completion of the FPPE until 90 percent compliance is maintained for six consecutive months.

VHA requires service chiefs to review OPPE data. "The OPPE is essential to confirm the quality of care delivered" and allows leaders to identify trends that may adversely affect patient safety.[38] The OIG found that some privileging folders lacked evidence service chiefs reviewed LIPs' OPPE data on a regular basis. As a result, the LIPs may have continued to deliver care without a thorough evaluation of their practice, which could have jeopardized quality of care and patient safety. The Chief of Staff attributed the inconsistent review of OPPE data to an ineffective tracking mechanism and service line staff's inability to monitor the process due to departmental vacancies.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs consistently review Ongoing Professional Practice Evaluation data.

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

Healthcare system concurred.

Target date for completion: March 1, 2024

Healthcare system response: Chief of Staff evaluated and determined that there were no additional reasons for noncompliance. Executive Leadership approved an additional position for a Credentialing Analyst, The Credentialing Analyst primary responsibility will be to ensure services are compliant with tracking and consistently reviewing Ongoing Professional Practice Evaluations (OPPE) data. Additionally, each Service Chief developed an internal tracking process to ensure timely completion of data evaluation and reviews with providers. Audit reports will continue to be submitted to the Executive Committee of the Medical Staff which is the governance committee responsible for maintaining oversight and compliance. The facility will continue to monitor the compliance of the OPPE data review until 90 percent compliance is maintained for six consecutive months.

VHA required the chief of staff to ensure providers with similar training and privileges evaluate LIPs on an ongoing basis.[39] The OIG found that some OPPEs contained results that were not based on a similarly trained and privileged provider's evaluation, which could have resulted in inadequate evaluations of LIPs' practices. The Chief of Staff reported that the Administrative Officer ensured providers with similar training and privileges evaluated LIPs; however, during the Administrative Officer's absence, temporarily assigned staff were unaware of this requirement.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.

[39] VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners," August 29, 2016. (This memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on December 18, 2020. The December 18, 2020, memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on May 18, 2021.) VHA now requires another practitioner with equivalent specialized training and similar privileges to complete the professional practice evaluation. VHA Directive 1100.21(1).

Healthcare system concurred.

Target date for completion: February 1, 2024

Healthcare system response: Chief of Staff evaluated and determined that there were no additional reasons for noncompliance. The Credentialing Officer identified all solo providers within the clinical services and senior clinical leaders were re-educated in July of 2022 on the requirement for Ongoing Professional Practice Evaluations (OPPE) to be completed by similarly trained and privileged clinicians. This reminder has been placed on each provider binder that contains OPPE data that is to be reviewed. Additionally, the facility is actively utilizing the newly established VISN process for assignment and completion of outside reviews by similarly trained and privileged clinicians. The Credentialing Officer will monitor each OPPE cycle for outside reviewer compliance of solo providers. Compliance will be reported by the Credentialing Officer monthly to the Executive Committee of the Medical Staff. Ninety percent compliance is expected and will be monitored 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.[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 environment in accordance with applicable standards.[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 during emergencies and contribute to a safe healthcare environment.[43]

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[40] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded and replaced this directive with VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.)

[41] The OIG did not physically inspect the healthcare system.

[42] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," November 17, 2021, 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.

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."[44] 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."[45]

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.[46] 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."[47] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from the Urgent Care Clinic and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG reviewed the electronic health records of 42 patients who were seen in the Urgent Care Clinic from December 31, 2020, through August 1, 2021.

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

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

[46] 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.)

[47] Deputy Under Secretary for Health for Operations and Management memo, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives," October 17, 2019. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions," October 1, 2021.)

Mental Health Findings and Recommendations

VHA requires staff to "complete 100% of required universal and setting-specific screenings and CSREs [Comprehensive Suicide Risk Evaluations]."[48] Additionally, all patients who screen positive for suicide risk in the emergency department or urgent care center must have a Comprehensive Suicide Risk Evaluation that includes an assessment of whether the patient's current suicidal ideation was the most severe in the last 30 days.[49] The OIG determined that 9 of 42 electronic health records reviewed lacked evidence providers completed the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen. Additionally, the OIG determined that of the 33 evaluations completed, 8 did not have evidence providers assessed the severity of the patient's most recent suicidal ideation.

Failure to evaluate patients following a positive suicide risk screen could result in missed opportunities for providers to identify those who are at increased risk for suicide. The Section Chief, Urgent Care Clinic identified less than optimal staffing during the OIG review time frame as a possible reason for noncompliance. According to the section chief, most patients were admitted from the Urgent Care Clinic to the mental health inpatient unit, where providers completed the evaluation. Although infrequent, providers sometimes did not complete the evaluation prior to transferring patients to an outside facility. The Suicide Prevention Coordinator acknowledged there was limited evidence providers assessed suicidal ideation severity using the Comprehensive Suicide Risk Evaluation and attributed the noncompliance to providers documenting suicidal ideation elsewhere in the electronic health record.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen and include an assessment of whether the current suicidal ideation was the most severe in the last 30 days.[50]

[48] 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);" 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)."

[49] 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);" 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)."

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

Healthcare system concurred.

Target date for completion: Completed.

Healthcare system response: The Chief of Staff evaluated and determined there were no additional reasons for noncompliance. Monitoring of electronic health records for completion of the Comprehensive Suicide Risk Evaluation following a positive Columbia-Suicide Severity Rating Scale Screen began in July 2022 with results reported to the Quality Leadership Board (QLB) monthly. Monitoring for an assessment of whether the current suicidal ideation was the most severe in the last 30 days started in October 2022. Suicide Prevention Coordinator is responsible for monitoring electronic health records for completion of the Comprehensive Suicide Risk Evaluation following a positive Columbia-Suicide Severity Rating Scale Screen. Suicide Prevention Coordinator is responsible for monitoring the outcomes of assessment to determine whether the current suicidal ideation was the most severe in the last 30 days. The results reported for six consecutive months have been greater than 90 percent compliant.

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 safety issues or adverse events. The recommendations are attributable to the Chief of Staff. The intent is for leaders to use 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	• None
Medical Staff Privileging	• Service chiefs complete Focused Professional Practice Evaluations. • Service chiefs consistently review Ongoing Professional Practice Evaluation data. • Providers with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.
Environment of Care	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen and include an assessment of whether the current suicidal ideation was the most severe in the last 30 days.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 16.[1]

Table B.1. Profile for Alexandria VA Health Care System (502) (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	$255,537,507	$357,748,327	$403,662,899
Number of:			
• Unique patients	31,730	31,219	31,400
• Outpatient visits	330,132	266,572	289,664
• Unique employees§	994	1,002	1,026
Type and number of operating beds:			
• Community living center	90	90	90
• Medicine	24	24	24
• Mental health	30	30	30
Average daily census:			
• Community living center	51	47	35
• Medicine	3	5	5
• Mental health	24	17	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).*

[1] VHA medical facilities are classified according to a complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no 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.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 23, 2023

From: Director, South Central VA Health Care Network (10N16)

Subj: Comprehensive Healthcare Inspection of the Alexandria VA Health Care System in Pineville, Louisiana

To: Director, Office of Healthcare Inspections (54CH02)

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

1. The South Central VA Health Care Network has reviewed and concurs with the recommendations in the OIG report entitled Comprehensive Healthcare Inspection of the Alexandria VA Health Care System, Pineville, Louisiana. Further, I have reviewed and concur with the facility's response to the recommendations.
2. If you have questions regarding the information submitted, please contact the VISN 16 Quality Management Officer.

(Original signed by:)

Skye McDougall, PhD
VISN 16 Network Director

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: August 18, 2023

From: Director, Alexandria VA Health Care System (502)

Subj: Comprehensive Healthcare Inspection of the Alexandria VA Health Care System in Pineville, Louisiana

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of the Alexandria VA Healthcare System in Louisiana. I will ensure that each recommendation is addressed. I concur with the recommendations.
2. Alexandria VA Healthcare System remains committed to ensuring our Veterans receive exceptional health care.

(Original signed by:)

Peter C. Dancy, FACHE
Medical Center Director

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