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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

CHIP Report | **22-00074-218** | **September 29, 2023**

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Figure 1. *Biloxi VA Medical Center of the Gulf Coast Veterans Health Care System in Mississippi.*

Source: https://www.va.gov/gulf-coast-health-care/locations/.

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Gulf Coast Veterans Health Care System, which includes the Biloxi VA Medical Center, multiple outpatient clinics in Alabama and Florida, and an outpatient clinic at Eglin Air Force Base in Florida. 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 Gulf Coast Veterans Health Care System during the week of August 15, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement and issued six recommendations to the System Director and Chief of Staff in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; and Environment of Care. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 24.

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 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 Gulf Coast Veterans 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 Gulf Coast Veterans Health Care System includes the Biloxi VA Medical Center, associated outpatient clinics in Alabama and Florida, and an outpatient clinic at Eglin Air Force Base in Florida. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from January 29, 2018, through August 19, 2022, the last day of the unannounced multiday evaluation.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

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

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

[5] The OIG's last comprehensive healthcare inspection of the Gulf Coast Veterans Health Care System occurred in January 2018. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in November 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. The healthcare system had a leadership team consisting of the System Director (Director), Chief of Staff, Associate Director of Patient Care Services (ADPCS), Associate Director, and Associate Director for Outpatient Operations. 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 approximately three months, with two leadership positions occupied by detailed (temporarily assigned) staff members. The ADPCS had served in the role since 2014 but was detailed to another position in January 2022, and the Deputy ADPCS was assigned to cover the ADPCS role. The associate director for outpatient operations position was vacated in May 2022 and two staff members were expected to cover the position until August 28, 2022, the projected start date

[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.

for the new Associate Director for Outpatient Operations. To help assess the executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Acting ADPCS, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $742,124,390 had increased by over 16 percent compared to the previous year's budget of $639,336,100.[10] The Director said the medical care budget was adequate and explained that because the COVID-19 pandemic negatively affected staffing, leaders had used some FY 2022 funds to hire 22 registered nurses and 65 clerks. The Director and Associate Director reported spending a significant amount of money on care in the community to support patients in their catchment area, which extended into northwest Florida.[11] The Associate Director discussed population growth in the Florida panhandle area, explaining the outpatient clinics in Pensacola and Panama City Beach were approximately five hours away from the Biloxi VA Medical Center. The Associate Director described a future goal of partnering with a local Navy facility near Pensacola to procure unused hospital space for inpatient care but acknowledged it would not be a swift process.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[13]

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

[11] VA pays for care by community providers in certain circumstances. "Community Care: Veteran Care Overview," Department of Veterans Affairs, accessed April 18, 2023, https://www.va.gov/COMMUNITYCARE/programs/veterans/index.asp.

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

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

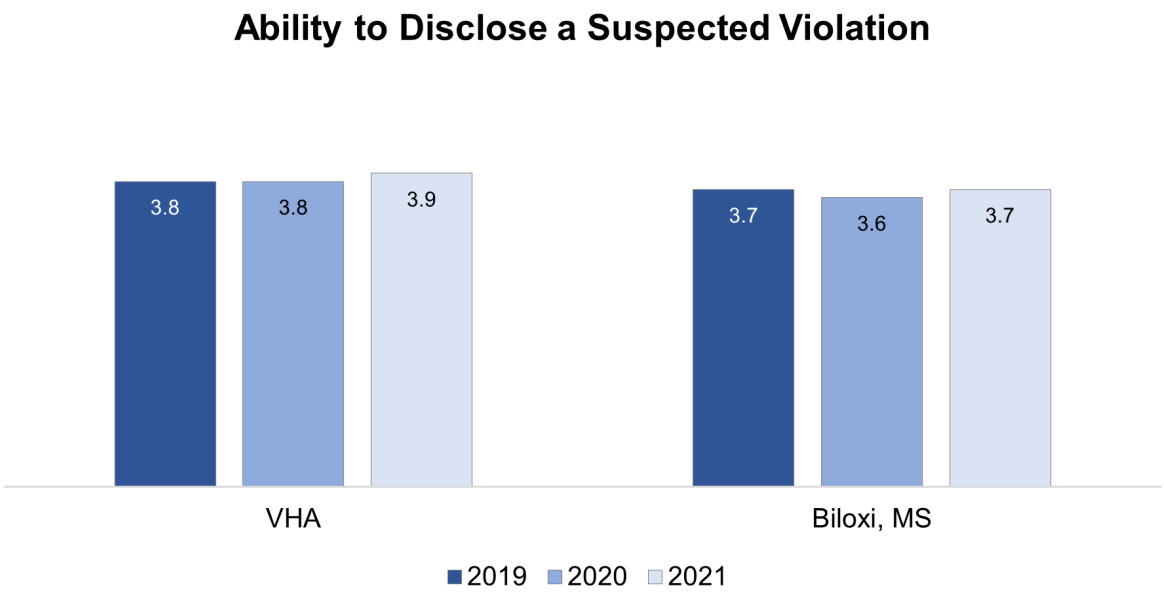

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed July 12, 2022).

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

Patient Experience

Veterans Health Administration (VHA) uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.[14]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the healthcare system over time.[16]

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

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

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

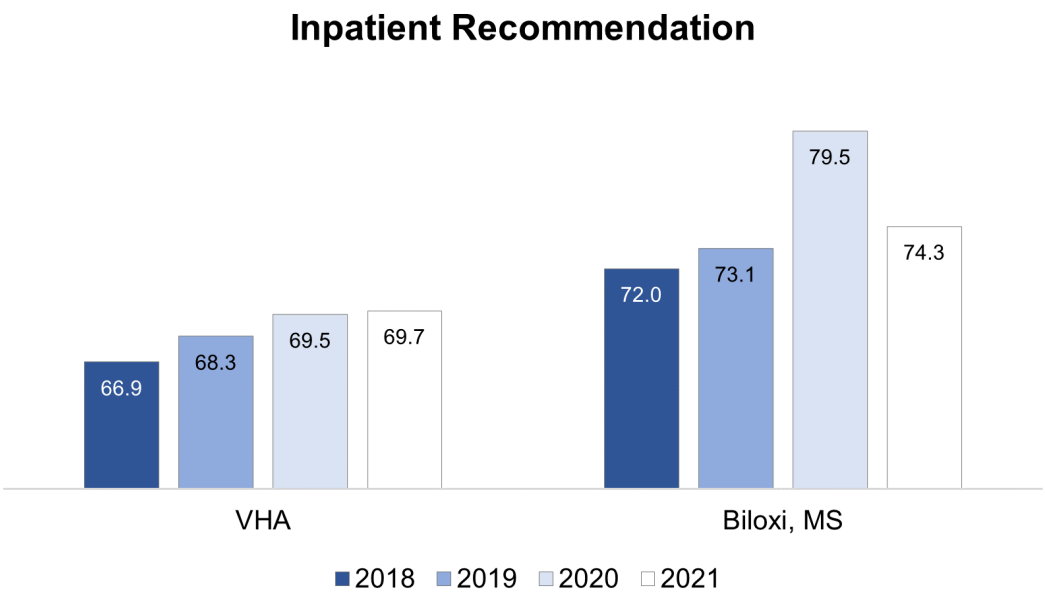

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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

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

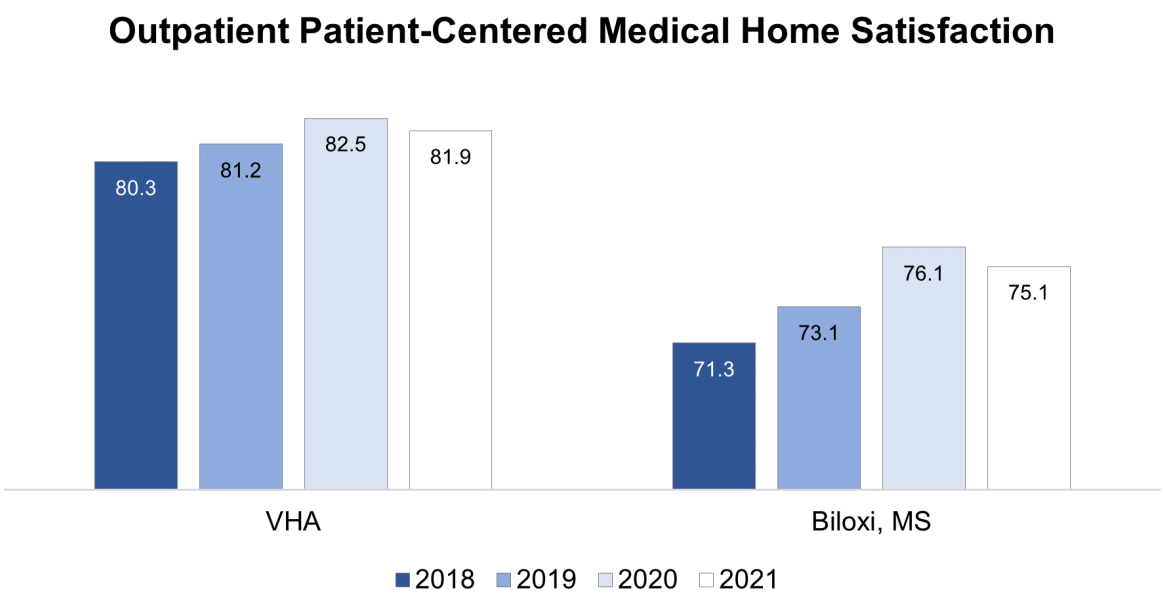

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

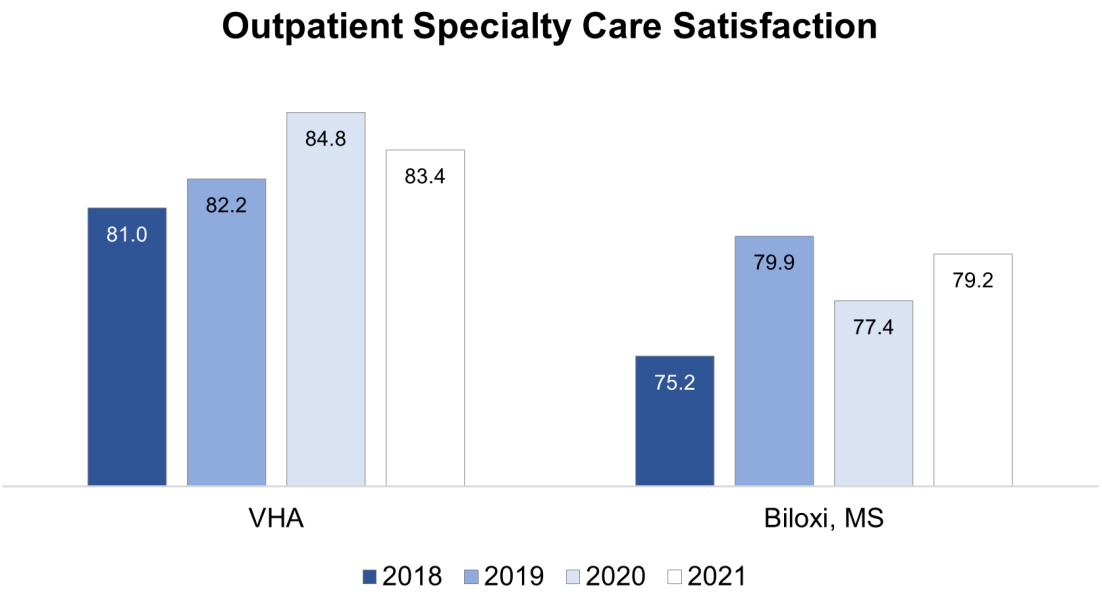

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] "A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[18] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and

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

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

recourse."[19] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[20] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

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

The OIG requested sentinel events and institutional and large-scale disclosures that occurred from January 29, 2018, to August 15, 2022, and reviewed the information staff provided. The Director reported being briefed about adverse events by the Patient Safety Manager or other executive leaders. The Director also stated that most adverse events, such as falls, did not rise to the level of institutional disclosure, but the Patient Safety Manager would discuss them with executive leaders if they were significant. The Director added that the disclosure process involved the Patient Safety and Risk Managers meeting with the Chief of Staff, who made the final determination about the type of disclosure warranted.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[20] VHA Directive 1004.08.

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

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

Quality, Safety, and Value

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

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

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

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

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

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

[24] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (VHA rescinded 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 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/hospitalusersguide.pdf.

Quality, Safety, and Value Findings and Recommendations

TJC leadership standards state the facility's governing body is ultimately responsible for patient safety and quality of care.[30] VA defines governance as "the process by which VA Senior Leadership makes decisions, provides strategic direction, and maintains accountability in a transparent and collaborative manner."[31] Further, TJC expects leaders to use "data and information to guide decisions and to understand variation" in patient safety and quality processes.[32]

The OIG identified that the Executive Leadership Board was to serve "in an advisory capacity to the Director for making informed decisions on matters pertaining to policy, planning, and performance."[33] The Director acknowledged the board had not met since May 2018. The OIG found that leaders were not following their policy and charter for this board, which required meeting quarterly or a minimum of four times annually.[34] Additionally, the OIG was unable to evaluate how leaders reviewed aggregated data and tracked improvement processes to completion. The lack of a process for executive leaders to identify, review, and improve system vulnerabilities may represent an organizational risk.

The Director said the Executive Leadership Board had no value because issues brought to the board had previously been discussed in other meetings. The Director further stated that leaders had planned to restructure board membership to make it more robust by involving staff from a variety services. The Director attributed some of the extended delay in restructuring the board to the COVID-19 pandemic, explaining that leaders had become involved in managing pandemic needs, lost focus on restructuring board membership, and experienced executive leadership turnover.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures leaders follow their defined governance structure.

[30] TJC, *Standards Manual*, E-dition, LD.01.03.01 and LD.03.07.01, July 1, 2021.

[31] VA Directive 0214, *Enterprise Governance Structure and Process*, May 14, 2019.

[32] TJC, *Standards Manual,* E-dition, LD.03.02.01, July 1, 2021.

[33] Gulf Coast Veterans Health Care System Charter-00-21-21, *Executive Leadership Board*, November 1, 2021.

[34] Gulf Coast Veterans Health Care System Memorandum, *Executive Leadership Board*, August 17, 2016; Gulf Coast Veterans Health Care System Charter-00-21-21, *Executive Leadership Board*.

Healthcare system concurred.

Target date for completion: January 31, 2024

Healthcare system response: The factors related to the recommendation were reviewed and no additional reasons for noncompliance were identified. The facility conducted an exhaustive review of the needs of the Gulf Coast Veterans Health Care System (GCVHCS) in relation to a formalized governance structure to design an architecture for governance that facilitates an effective, efficient, and hardwired system for oversight of the operations of the healthcare system. This review and design for a new governance structure was conducted in conjunction with collaboration and guidance from the VISN 16 Quality Management Officer prior to the final completion of the governance structure by signature of the GCVHCS Medical Center Director on July 26, 2023.

With the new governance structure finalized, GCVHCS constituted an Executive Leadership Board (ELB) to receive data reflecting the status of operations of the healthcare system utilizing the channels of tiered review founded on the new governance structure. The ELB is the highest-tiered committee structure to provide oversight and ensure the healthcare system is delivering Veteran-centric health care under an integrated enterprise-wide framework of quality, safety, and value. The charter for the ELB was finalized and signed by the GCVHCS Medical Center Director on August 30, 2023. The ELB held the first meeting codified by this charter and founded on the new governance structure on August 31, 2023.

With full corrective actions for this recommendation completed by the facility, the facility will submit six consecutive months of ELB minutes (August 2023 to January 2024) to demonstrate oversight guided by the new governance structure and evaluated through the ELB. The facility will request closure of this recommendation with the submission of the new governance structure, ELB charter, and six consecutive months of ELB meeting minutes.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[35] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[36]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[37] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[38]

VHA 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.[39]

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.[40] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the chief of staff. VHA also requires facilities to have credentialing

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

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[41]

The OIG interviewed key managers and selected and reviewed the privileging folders of 30 medical staff members who had an FPPE or OPPE.

Medical Staff Privileging Findings and Recommendations

VHA requires the FPPE process "to be defined in advance, using objective criteria accepted by the LIP."[42] The OIG reviewed LIPs' privileging folders and found that all lacked evidence the LIPs were aware of and had accepted the evaluation criteria before service chiefs initiated the FPPE process. When LIPs are not informed of the evaluation criteria, they may not understand FPPE expectations. The Chief of Staff reported that service chiefs completed LIP orientation processes at the service level, often having verbal conversations regarding FPPE criteria, but there was no standardized procedure across services to document these conversations. 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 requires that, at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific OPPE data when recommending the continuation of LIPs' privileges to an executive committee of the medical staff. These data are maintained as part of the LIPs' profile and may include direct observation, clinical discussions with other members of the care team, and review of diagnoses and treatments.[43] The OIG noted that some OPPEs lacked service-specific criteria. This may have resulted in LIPs continuing to deliver care without thorough reviews of their practices, which could adversely affect safe patient care. The Chief of Staff reported staff were updating OPPE forms to include service-specific elements, but because the OIG's review was retrospective, it did not capture the updated documentation.

Additionally, the OIG found that for some OPPEs, service chiefs did not have data in the LIPs' privileging folders to support the evaluation. The Chief of Staff reported that service chiefs maintained OPPE data at the service level, but these data could not be located due to five service chiefs leaving the facility within the previous two years.

[41] 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.

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

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

Recommendation 2

2. The Chief of Staff determines any additional reasons for noncompliance and ensures leaders use service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.

Healthcare system concurred.

Target date for completion: March 31, 2024

Healthcare system response: The factors related to the recommendation were reviewed and no additional reasons for noncompliance were identified. The Professional Credentials Office for Gulf Coast Veterans Health Care System in conjunction with the Service Chiefs has revised all ongoing professional practice evaluation (OPPE) forms for compliance. Each form has been standardized to contain: 1) VHA standards I, II and III common to each service, 2) clinical indicators identified by national which are specific to each service, and 3) facility specific clinical indicators. Each OPPE form will be reviewed by the Credentialing Committee and Executive Committee of the Medical Staff during meetings scheduled for September 5, 2023. Each service will have providers acknowledge the new OPPE forms no later than September 22, 2023. The new forms will be implemented for FY 24 OPPE Cycle 1 (October 1, 2023, to March 31, 2024). The Professional Credentials Office utilizes an operations tracker that is shared with the COS [Chief of Staff], Service Chiefs, and administrative stakeholders for situational awareness. All reporting will be pulled from this tracker. All approved forms are located on the Professional Credentials Office SharePoint site and are the only ones authorized for use in FY24 unless completing an FPPE started prior to FY24. The Professional Credentials Office will conduct monthly audits of 10% of reviews for each service evaluating for completion and use of service specific criteria. Benchmark status will be set at six consecutive months of audits revealing at least 90 percent overall compliance. Compliance rates for audits will be reported to the facility's Quality and Patient Safety Committee.

Recommendation 3

3. The Chief of Staff determines any additional reasons for noncompliance and ensures service chiefs maintain Ongoing Professional Practice Evaluation data in licensed independent practitioners' privileging folders.

Healthcare system concurred.

Target date for completion: March 31, 2024

Healthcare system response: The factors related to the recommendation were reviewed and no additional reasons for noncompliance were identified. The Professional Credentials Office has created a Teams channel to serve as a repository for each service to index copies of their ongoing professional practice evaluation (OPPE) summary sheets and data used to support the summaries. Staff within the Professional Credentials Office conducts daily updates to the operations tracker based on the information in the Teams channel to mirror the information contained within the practitioners' privileging folder daily. Staff account for and check compliance of the OPPE summary sheets and data loaded into Teams against the number of licensed independent practitioners enrolled in VetPro. The Professional Credentials Office utilizes an operations tracker that is shared with the COS, Service Chiefs, and administrative stakeholders for situational awareness. All reporting will be pulled from this tracker. The Professional Credentials Office will audit 10% of each service's provider profile files to ensure that data associated with the review being audited is present. Benchmark status will be set at six consecutive months of audits revealing at least 90 percent overall compliance. Compliance rates for audits will be reported to the facility's Quality and Patient Safety Committee.

VHA required practitioners with similar training and privileges to complete professional practice evaluations.[44] The OIG did not find documentation that another practitioner with similar training and privileges evaluated some LIPs. This resulted in LIPs practicing without comprehensive evaluations, which could cause specific practice deficiencies to go unnoticed and pose patient safety risks. The Chief of Staff reported that service chiefs maintained the documentation at the service level, but staff could not locate it due to five service chiefs leaving the facility within the previous two years.

[44] Acting Deputy Under Secretary for Health for Operations and Management memo, VHA Memorandum, 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).

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures practitioners with equivalent specialized training and similar privileges complete professional practice evaluations of licensed independent practitioners.

Healthcare system concurred.

Target date for completion: March 31, 2024

Healthcare system response: The factors related to the recommendation were reviewed and no additional reasons for noncompliance were identified. The Professional Credentials Office has hired an additional program analyst to maintain adequate staffing to effectively track professional practice evaluation forms. Services are sent a copy of the tentative agenda reminding them of the reporting requirement and who is due to be reported on 10 days prior to help with sustainment. Additionally, the providers FPPE is added to the shared tracker with comments for when the provider is due. Staff from the Professional Credentials Office compare reviewers' privileges on file to the reviewees on each submitted review to ensure equivalent specialized training and similar privileges. The Professional Credentials Office utilizes an operations tracker that is shared with the COS, Service Chiefs, and administrative stakeholders for situational awareness. All reporting will be pulled from this tracker. The Professional Credentials Office will audit 10% of provider files for each service checking the privileges of the reviewer against those of the reviewee and the VetPro Profile to analyze whether reviews were conducted by providers with similar privileges and training. Benchmark status will be set at six consecutive months of audits revealing at least 90 percent overall compliance. Compliance rates for audits will be reported to the facility's Quality and Patient Safety Committee.

VHA requires service chiefs to document FPPE results and report them to an executive committee of the medical staff. Additionally, at the time of reprivileging, VHA requires the executive committee of the medical staff to review the service chief's recommendation along with clinical competence information when making privileging recommendations to the facility director.[45] The OIG found that service chiefs did not report all of the FPPE results to the Executive Committee of the Medical Staff. The OIG identified a similar concern during the prior CHIP site visit in 2018.[46]

Further, for some of the OPPEs reviewed, the OIG noted the Executive Committee of the Medical Staff meeting minutes did not include the recommendation to continue LIPs' privileges;

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

[46] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Gulf Coast Veterans Health Care System, Biloxi, Mississippi*, September 11, 2018.

or the committee recommended reprivileging, despite the OPPEs not having the service chiefs' signature for recommendation. Failure to properly review evaluations and data may result in incomplete evidence for the committee to consider in recommending privileges. The Chief of Staff explained that service chiefs reported LIPs' FPPE and OPPE results to the Credentialing Committee (a subcommittee of the Executive Committee of the Medical Staff), but due to a lack of attention to detail, the Credentialing Committee meeting minutes or executive summary reports were not included in the Executive Committee of the Medical Staff meeting minutes.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Executive Committee of the Medical Staff reviews the service chiefs' recommendations along with clinical competence information when making privileging recommendations for licensed independent practitioners.

Healthcare system concurred.

Target date for completion: March 31, 2024

Healthcare system response: The factors related to the recommendation were reviewed and no additional reasons for noncompliance were identified. The Professional Credentials Office reviews the focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE) forms for compliance to include dates, current clinical indicators, benchmarks met, whether the review was conducted by a provider of similar privileges and training, and whether the provider and service chief signatures are present on the forms. Any non-compliant forms are returned to the respective service for corrections. The completed FPPE and OPPE forms are gathered and displayed in a presentation for all members of the Credentialing Committee to review and vote for approval or disapproval. The minutes from the Credentialing Committee are presented to the Executive Committee of the Medical Staff (ECMS) to review and provide a recommendation on the privileging or re-privileging of licensed independent practitioners. The Professional Credentials Office will monitor the monthly minutes of the Credentialing and ECMS meeting minutes. Benchmark status will be set at six consecutive months of audits revealing at least 90 percent overall compliance for presented practitioners. Compliance rates for audits will be reported to the facility's Quality and Patient Safety Committee to ensure compliance until benchmark of 90 percent has been met 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.[47] The physical environment of a healthcare organization must not only be functional but should also promote healing.

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG assessed compliance in selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[48]

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.[49] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times during emergencies and contribute to a safe healthcare environment.[50]

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

- Community living center (Niagara)

[47] 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.)

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

[49] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," November 17, 2021, accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[50] Opioids are medications that are "effective at reducing pain" but "when taken in excess, can lead to respiratory arrest." Naloxone "is a highly effective treatment for reversing an opioid overdose." "Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit," VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, "Automated External Defibrillators (AEDs)," accessed December 16, 2021, https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds. "Pharmacy Benefits Management Services," Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

- Emergency Department
- Intensive Care Unit
- Medical and surgical inpatient unit (4A)
- Mental health inpatient unit (25-2A)
- Specialty care clinic (Dental Clinic)

Environment of Care Findings and Recommendations

VHA requires staff to ensure a clean and safe healthcare environment.[51] The OIG found that staff had not cleaned areas where they kept patient food, including the refrigerators.[52] This could result in possible contamination of food or drinks provided to patients. The Administrative Section Chief explained the process was for staff to assess the areas when they deliver patient food to the rooms, clean them as needed, and for supervisors to conduct spot checks. The Acting Chief of Nutrition and Food Service attributed the noncompliance to lack of oversight.

Recommendation 6

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

Healthcare system concurred.

Target date for completion: March 31, 2024

Healthcare system response: The factors related to the recommendation were reviewed and no additional reasons for noncompliance were identified. GCVHCS Environmental Management Service (EMS) has developed service-specific tracers that will be utilized by EMS Supervisors to assess the cleanliness of patient care and non-patient care areas to ensure that the areas have been cleaned to standard by EMS housekeeping staff whereby areas are clean and debris-free. A minimum of 10 tracers will be conducted per month. The tracers will be submitted to the Chief of EMS for review and will be aggregated for the determination of a monthly compliance rate for the tracers. Benchmark status will be set at six consecutive months of audits revealing at least 90 percent overall compliance for submitted tracers reflecting that patient care areas and non-patient care areas are clean and debris-free. The results of the monthly audits will be reported to the Quality and Patient Safety Committee.

[51] VHA Directive 1608; VHA Directive 1608(1).

[52] The OIG noted the nourishment room shelves in the medical and surgical inpatient unit (4A) were not clean; the patient refrigerator in the Emergency Department was dirty and needed to be defrosted; and Nutrition and Food Service carts in the medical and surgical inpatient unit (4A), Emergency Department, and Intensive Care Unit were dirty.

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."[53] 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."[54]

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.[55] 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."[56] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from the Emergency Departments or urgent care center and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 48 randomly selected patients who were seen in the Emergency Department or urgent care center from December 31, 2020, through August 1, 2021.

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

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

[55] 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.)

[56] 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 six recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines six OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the System Director and 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	• Leaders follow their defined governance structure.
Medical Staff Privileging	• Leaders use service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners. • Service chiefs maintain Ongoing Professional Practice Evaluation data in licensed independent practitioners' privileging folders. • Practitioners with equivalent specialized training and similar privileges complete professional practice evaluations of licensed independent practitioners. • The Executive Committee of the Medical Staff reviews the service chiefs' recommendations along with clinical competence information when making privileging recommendations for licensed independent practitioners.
Environment of Care	• Staff 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 mid-high complexity (1c) affiliated healthcare system reporting to VISN 16.[1]

Table B.1. Profile for Gulf Coast Veterans Health Care System (520) (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	$480,966,657	$639,336,100	$742,124,390
Number of:			
• Unique patients	74,023	75,623	82,426
• Outpatient visits	777,846	736,159	822,369
• Unique employees§	2,144	2,176	2,175
Type and number of operating beds:			
• Community living center	101	101	101
• Domiciliary	72	72	74
• Medicine	24	24	24
• Blind rehabilitation	20	22	22
• Mental health	22	22	22
• Surgery	6	6	6
Average daily census:			
• Community living center	77	88	61
• Domiciliary	58	61	24
• Medicine	12	8	13
• Blind rehabilitation	16	19	–
• Mental health	18	20	19

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

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Average daily census (cont.):			
• Surgery	2	1	1

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: September 12, 2023

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

Subj: Comprehensive Healthcare Inspection of the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

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

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 Gulf Coast Veteran Healthcare System, Biloxi, Mississippi. 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: September 6, 2023

From: Medical Center Director, Gulf Coast Veterans Health Care System (520)

Subj: Comprehensive Healthcare Inspection of the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

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

1. Gulf Coast Veterans Health Care System has reviewed and concurs with this Healthcare Inspection report.
2. We recognize opportunities for improvements in our operations, and corrective actions have been implemented to address the recommendations.

(Original signed by:)

Stephanie Repasky, PsyD
Medical Center Director

OIG Contact and Staff Acknowledgments

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