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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Central Arkansas Veterans Healthcare System in Little Rock

CHIP Report | 22-00076-222 | September 29, 2023

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Figure 1. *John L. McClellan Memorial Veterans' Hospital of the Central Arkansas Veterans Healthcare System in Little Rock.*

Source: https://www.va.gov/central-arkansas-health-care/locations/ (accessed October 28, 2022).

Abbreviations

ADPCS	Associate Director for Patient Care Services/Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
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 Central Arkansas Veterans Healthcare System, which includes the John L. McClellan Memorial Veterans' Hospital (Little Rock), Eugene J. Towbin Healthcare Center (North Little Rock), and multiple outpatient clinics in Arkansas. 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 Central Arkansas Veterans Healthcare System during the week of July 18, 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 five recommendations to the Director and Chief of Staff in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; and Mental Health. 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 considers recommendations 1 and 3 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 Central Arkansas Veterans Healthcare System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

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

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

Methodology

The Central Arkansas Veterans Healthcare System includes the John L. McClellan Memorial Veterans' Hospital in Little Rock, Eugene J. Towbin Healthcare Center in North Little Rock, and associated outpatient clinics in Arkansas. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from April 23, 2018, through July 22, 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 Medical Center 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 Central Arkansas Veterans Healthcare System in Little Rock occurred in April 2018. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews 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. The healthcare system had a leadership team consisting of the Medical Center Director (Director); Deputy Executive Director; Chief of Staff; Associate Director for Patient Care Services/Nurse Executive (ADPCS); Chief, Quality, Safety, Value; and Associate Medical Center Director (Associate Director). 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 Director, ADPCS, and Associate Director had worked together for over five and a half years. The Deputy Executive Director and Chief, Quality, Safety, Value started in March 2022, and the acting Chief of Staff had served in the role for approximately one and a half months.[10] The Director discussed a focus on leadership

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

[8] Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

[10] The deputy executive director position was a new role. The Chief of Staff left in May 2022, and the Deputy Chief of Staff then assumed the acting chief of staff position.

development and described working with Veterans Health Administration's (VHA's) National Center for Organization Development on a leadership program to build a unified team and integrate the role of the new Deputy Executive Director into the organization.[11]

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $817,306,419 had increased almost 15 percent compared to the previous year's budget of $713,785,194.[12] The Director stated the budget increase was largely due to spending related to community care, which tripled in the past three years, and the COVID-19 pandemic.[13] The Director explained that it was necessary to use community care partners because of provider shortages and patients' distance from healthcare system facilities. The leader further reported expanded care options at the healthcare system's community-based outpatient clinics; in addition to primary care and mental health services, they now had physical therapy, chiropractic, and tele-audiology services. The Director also said that expenses increased during the pandemic and leaders used funds to hire temporary staff, pay employees overtime, and purchase equipment and supplies.

The Associate Director stated that since many veterans did not seek care at the hospital during the pandemic, this created higher patient volume and care costs as pandemic concerns began to lift. The leader also explained that staff referred patients to community care when the system was unable to provide services because of the increase in workload.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[14] 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.

[11] "NCOD [National Center for Organization Development] supports and delivers organizational health services for the U.S. Department of Veterans Affairs (VA)…To achieve this, [they] offer contemporary and innovative data-driven assessments and consultation services to VA organizations nationwide." "National Center for Organization Development," VA Healthcare, accessed October 27, 2022, https://www.va.gov/NCOD/. (This webpage is no longer accessible.)

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

[13] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care: Community Care Overview," Department of Veterans Affairs, accessed May 24, 2023, https://www.va.gov/communitycare/.

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

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[15]

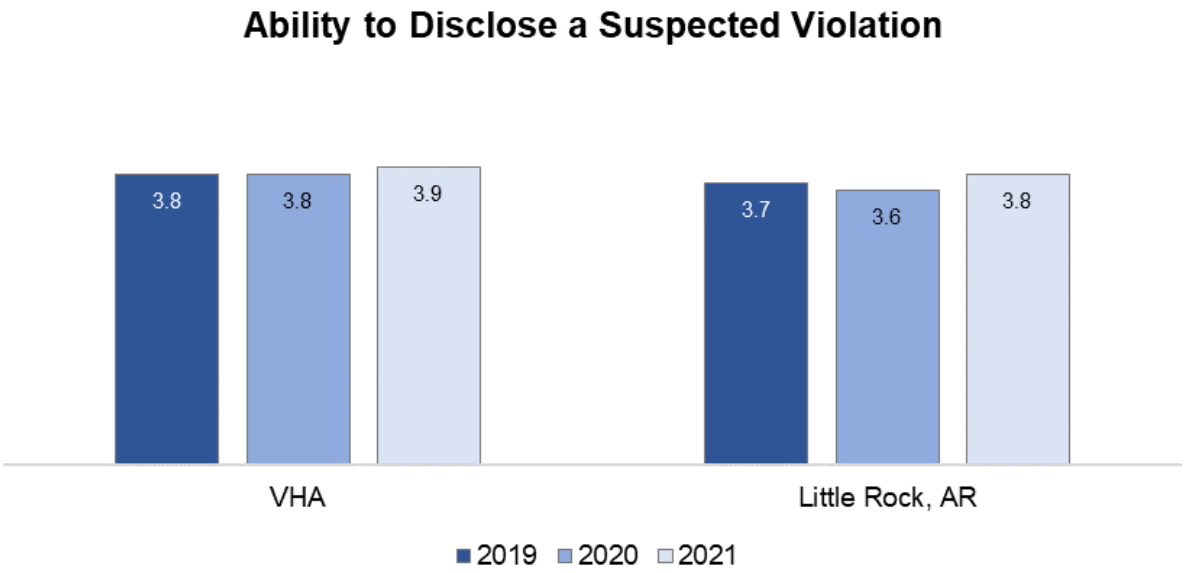

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed June 15, 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.[16]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[17] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare

[15] 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).

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

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

system from FYs 2018 through 2021. Figures 3-5 provide survey results for VHA and the healthcare system over time.[18]

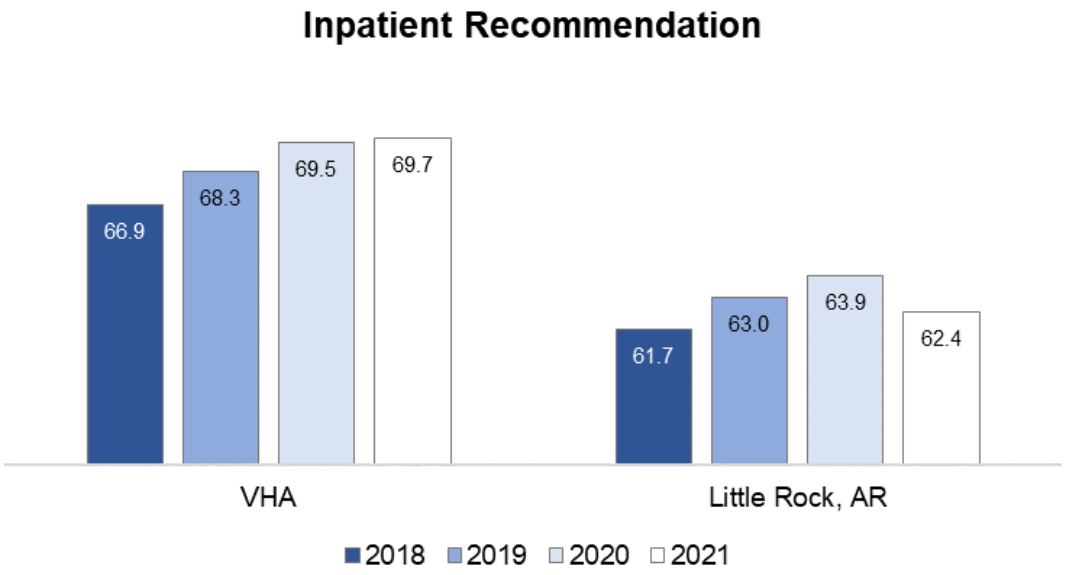

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

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

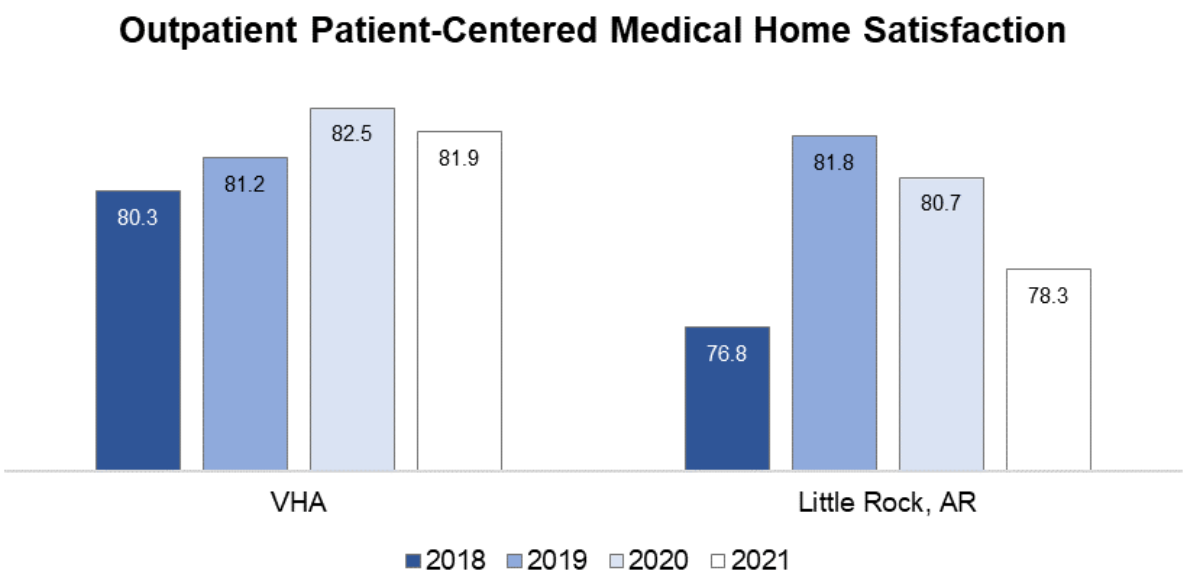

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

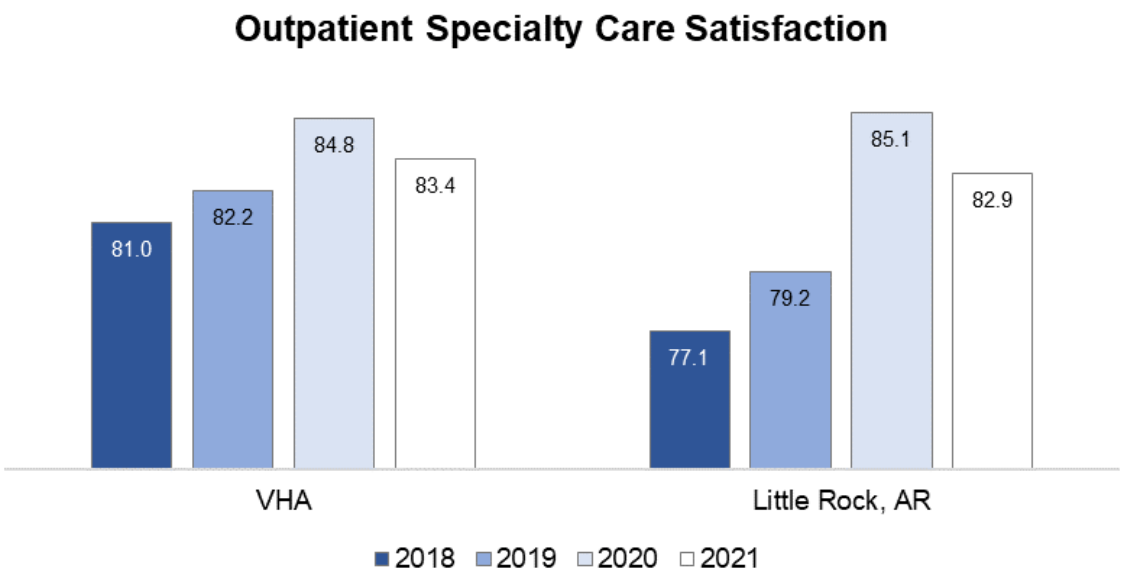

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[19] "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)."[20] 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

[19] 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/.

[20] 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."[21] 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."[22] 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.[23] 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.[24]

The OIG requested sentinel events and institutional and large-scale disclosures that occurred from April 23, 2018, to July 18, 2022, and reviewed the information staff provided. The Director described the importance of staff always considering safety, adverse event reporting, and the concept of a just culture. The Director indicated that a safety standdown, high reliability initiatives, committee and board safety incident discussions, town hall forums, Joint Patient Safety Reporting system education, the Director's anonymous reporting tool, and monthly newsletters all highlighted the importance of patient safety.[25] The Director stated that staff reported patient safety events at morning meetings and any time an event occurred. The Director also explained that leaders used mechanisms including root cause analysis investigations,

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

[22] VHA Directive 1004.08.

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

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

[25] "An HRO [High Reliability Organization] is an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results." "VHA's Vision for a High Reliability Organization," Department of Veterans Affairs, accessed March 16, 2022, https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm?ForumMenu=summer20-1. "JPSR [Joint Patient Safety Reporting] is a user-based web application for front-line VHA users which means that all and any event types are captured in the JPSR system. It is the charge of the PSM [patient safety manager] to process all reported events and determine which events meet the criteria of a patient safety event or close call for processing in JPSR." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

performance metrics, peer reviews, and quality improvement projects to prevent future occurrences.[26]

The ADPCS stated that when patient safety events occur after hours or on weekends, the nurse on duty notifies the leader who in turn alerts other executive team members. After notification, the ADPCS meets with the Patient Safety Manager and other staff involved; discusses the event, how to address it, and the patient's status; and determines appropriate follow-up actions such as root cause analyses or fact-finding investigations.[27] The Chief, Quality, Safety, Value stated the Patient Safety Manager reports monthly to the Joint Leadership Council, which reviews patient safety event trends.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[26] A root cause analysis is a focused review to identify the actual system- and process-related contributing factors of the event. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.) 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] Fact finding investigations are a "type of administrative investigation…for collecting and analyzing evidence, ascertaining facts and documenting complete and accurate information of interest to the initiating authority." VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021.

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."[28] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[29] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[30]

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. Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[31] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[32]

Finally, the OIG assessed the healthcare system's culture of safety.[33] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

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

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

[29] 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.)

[30] VHA Directive 1100.16.

[31] VHA Directive 1190.

[32] VHA Directive 1190.

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

Quality, Safety, and Value Findings and Recommendations

VHA requires staff to complete an individual root cause analysis for all events assigned an actual or potential safety assessment code score of 3.[34] The OIG found that staff did not consistently complete a root cause analysis for patient safety events with an actual or potential safety assessment code score of 3, occurring between June 1, 2021, and May 31, 2022. When adverse events are not thoroughly investigated, it may delay staff in identifying quality of care concerns and needed patient safety improvements. The patient safety managers were not able to provide a reason for staff not completing root cause analyses.

Recommendation 1

1. The Director determines the reasons for noncompliance and ensures staff complete an individual root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.[35]

Healthcare system concurred.

Target date for completion: Completed.

Healthcare system response: The Medical Center Director and Chief of Staff reviewed and did not determine any additional reasons for noncompliance. Central Arkansas Veterans Healthcare System Patient Safety Managers along with Risk Manager implemented a spreadsheet to track all severity assessment code (SAC) 3 cases. Patient Safety Managers and Risk Manager meet twice a month to discuss all the SAC 3 cases and also pull a SAC 3 report monthly and reconcile with the spreadsheet to ensure there is a root cause analysis (RCA) completed for all patient safety events assigned an actual or potential SAC score of 3. Central Arkansas Veterans Healthcare System Patient Safety Managers began monitoring and reporting to Quality, Safety, Value Board chaired by Medical Center Director and Chief of Staff monthly in August 2022 and have continued monitoring and reporting through July 2023 with 100 percent compliance from September 2022 through July 2023.

[34] Adverse events and close calls are assigned a safety assessment code score based on the severity of the event and how often it occurs. The safety assessment code score is ranked as 3 = highest risk, 2 = intermediate risk, 1 = lowest risk. VHA Handbook 1050.01; VHA Directive 1050.01.

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

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."[36] 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."[37]

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

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[40]

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.[41] 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

[36] 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.)

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[42]

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

Medical Staff Privileging Findings and Recommendations

VHA requires FPPE criteria "to be defined in advance, using objective criteria accepted by the LIP."[43] The OIG reviewed privileging folders and found inconsistent evidence 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 OIG learned that service chiefs had verbal conversations with newly hired LIPs regarding criteria in advance; however, there was no documentation to support those conversations took place. 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.

Additionally, VHA states the FPPE is a defined period during which the service chief "evaluates and determines the LIP's professional performance."[44] The OIG found inconsistent evidence that FPPEs had a defined time frame for the expected review period. This may result in LIPs providing care without a thorough and timely evaluation of their competencies, which could adversely affect quality of care and patient safety. The Credentialing and Privileging Manager reported that leaders did not have a clear FPPE process across all service lines.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs define time frames for Focused Professional Practice Evaluations.

[42] 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.

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

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

Healthcare system concurred.

Target date for completion: July 31, 2024

Healthcare system response: The Chief of Staff reviewed and did not determine any additional reasons for noncompliance. Central Arkansas Veterans Healthcare System adopted the Focused Professional Practice Evaluation (FPPE) data summary form in June 2023. The FPPE data summary form includes defined time frames for the expected review period. The Credentialing and Privileging Manager and Deputy Chief of Staff provided education and are working with services to complete all forms correctly. The Credentialing and Privileging Manager will present all FPPE summary forms which include the defined time frames to the Professional Standard Committee (PSC) and Medical Executive Board (MEB) monthly. Numerator: The number of individual provider FPPE forms that are completed correctly for the month. Denominator: Total number of completed individual provider FPPE forms for the month. Compliance will be monitored and reported to Quality, Safety, Value Board, chaired by Medical Center Director and Chief of Staff monthly until 90 percent or greater compliance is achieved and sustained for 6 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.[45] 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.[46]

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.[47] 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.[48]

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:

- John L. McClellan Memorial Veterans' Hospital

[45] 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.)

[46] 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.

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

[48] 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 (surgical)
  - Medical/surgical inpatient unit (6D)
  - Specialty care clinic (ear, nose, and throat)
- Eugene J. Towbin Healthcare Center
  - Community living center (1B)
  - Mental health inpatient unit (3K)
  - Primary care clinic (geriatric)

Environment of Care Findings and Recommendations

The OIG made no recommendations.

Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives

Suicide prevention remains the top clinical priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides among U.S. adults."[49] Additionally, "among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019."[50]

VHA implemented various evidence-based approaches to reduce veteran suicides, including a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[51] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from emergency departments or urgent care centers and receive "structured post-discharge follow-up to facilitate engagement in outpatient mental health care."[52] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from the Emergency Department and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed staff and managers and reviewed the electronic health records of 47 randomly selected patients who were seen in the Emergency Department from December 31, 2020, through August 1, 2021.

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

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

[51] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

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

Mental Health Findings and Recommendations

VHA requires clinicians to screen patients seen in the emergency department or urgent care center for suicide risk and if positive, complete a Comprehensive Suicide Risk Evaluation.[53] The OIG found that 32 percent of electronic health records reviewed lacked evidence clinicians completed a Comprehensive Suicide Risk Evaluation following the patient's positive suicide risk screen. Failure to evaluate these patients could result in missed opportunities for clinicians to identify those who are at increased risk of suicide. The Service Chief, Emergency Medicine Service reported a lack of ownership for the suicide prevention processes in the Emergency Department as a contributing factor for the finding.

Recommendation 3

3. The Director evaluates and determines any additional reasons for noncompliance and ensures clinicians complete a Comprehensive Suicide Risk Evaluation following a positive suicide risk screen for patients seen in the Emergency Department.[54]

[53] 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)."

[54] 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 Medical Center Director and Chief of Staff reviewed and did not determine any additional reasons for noncompliance. Central Arkansas Veterans Healthcare System Suicide Prevention Team implemented a process of monitoring a report three times a day that allows the Suicide Prevention Team to identify all positive Columbia Suicide Severity Rating Scale (C-SSRS) screens that were not accompanied by a Comprehensive Suicide Risk Evaluation (CSRE). In the event of a missing CSRE, the Suicide Prevention Team reaches out to the appropriate staff to inform them that a CSRE is required. There is also a staff member who monitors the report on weekends. Additionally, the Emergency Department (ED) social work (SW) staff is now present 24/7, 365 days per year. The ED uses the Integrated System electronic board which the status is changed to purple when the C-SSRS is positive. The triage Registered Nurse gives a warm handoff to the ED SW staff and adds ED SW staff as co-signer to the triage note when a CSRE is required. If the Veteran is not willing to participate in the CSRE, the ED SW staff will document the refusal in the CSRE note template. A report was run three times a day during the week and daily on the weekends. When there was a positive C-SSRS, the medical record was reviewed to determine if a CSRE was completed. If not, a message was sent to the appropriate provider. The medical record was then monitored to ensure the CSRE was completed timely. If not, a Joint Patient Safety Report was entered. Central Arkansas Veterans Healthcare System Suicide Prevention Team began monitoring and reporting to Quality, Safety, Value Board chaired by Medical Center Director and Chief of Staff monthly in September 2022 and have continued monitoring and reporting through July 2023 with 92 percent or greater compliance monthly from September 2022 through July 2023.

VHA requires clinicians to ensure that patients who are identified as intermediate, high-acute, or chronic risk-for-suicide and are determined safe for discharge home from an emergency department have a safety plan created or updated prior to discharge. Further, VHA requires that at a minimum, clinicians must contact these patients weekly by telephone or in-person until they have attended an outpatient mental health appointment or been admitted to an inpatient or residential facility.[55] The OIG found that of the five patients identified as intermediate, high-acute, or chronic risk-for-suicide and discharged from the Emergency Department, clinicians did not complete the suicide safety plan prior to discharge for one patient and did not follow-up within seven days for another.

[55] 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;" 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."

Lack of follow-up care may lead to missed opportunities for clinicians to provide support, continue risk mitigation, ensure smooth care transition, and monitor continuity of care. The Service Chief, Emergency Medicine Service reported a lack of ownership for the suicide prevention processes between Emergency Department, mental health, and primary care teams as a contributing factor for the findings.

Recommendation 4

4. The Director evaluates and determines any additional reasons for noncompliance and ensures clinicians create or update a suicide safety plan for patients determined to be at intermediate, high-acute, or chronic risk-for-suicide and safe to discharge home from the Emergency Department.

Healthcare system concurred.

Target date for completion: July 31, 2024

Healthcare system response: The Medical Center Director and Chief of Staff reviewed and did not determine any additional reasons for noncompliance. Central Arkansas Veterans Healthcare System (CAVHS) has staffed social workers in the Emergency Department. Emergency Department social workers complete the Suicide Safety Plan in the Emergency Department to ensure there is a Suicide Safety Plan completed or updated for patients determined to be at intermediate, high-acute, or chronic risk-for-suicide and are safe to discharge home from the Emergency Department. All Suicide Prevention Emergency Department (SPED) eligible patients show up on the dashboard within one to three days, then the Suicide Prevention Program Manager reviews the charts in the medical record. The Suicide Prevention Program Manager reviews the dashboard at least weekly and alerts the Emergency Department Social Work supervisor when there is a missed Safety Plan. The supervisor contacts staff and re-educates staff on the SPED requirements and ensures that documented efforts are made to follow up with the Veteran by phone to assess for safety and make efforts to engage the Veteran in completion of the Safety Plan by phone. Social workers offer and attempt completion of safety plans on all Veterans who present to the Emergency Department with a positive Columbia-Suicide Severity Rating Scale Screener, regardless of risk stratification. Social workers in the Emergency Department document efforts to contact all Veterans who leave against medical advice, without being seen, or elopement status. Emergency Department social workers monitor and track these efforts and report any concerns to facility leadership when needed. Compliance will be monitored and reported to Quality, Safety, Value Board, chaired by Medical Center Director and Chief of Staff monthly until 90 percent or greater compliance is achieved and sustained for 6 consecutive months.

Recommendation 5

5. The Director evaluates and determines any additional reasons for noncompliance and ensures clinicians follow up within seven days with patients determined to be at intermediate, high-acute, or chronic risk-for-suicide who were discharged home from the Emergency Department.

Healthcare system concurred.

Target date for completion: July 31, 2024

Healthcare system response: The Medical Center Director and Chief of Staff reviewed and did not determine any additional reasons for noncompliance. Central Arkansas Veterans Healthcare System Suicide Prevention Team monitors the Suicide Prevention in Emergency Department (SPED) dashboard daily to ensure there is a seven-day follow-up with patients determined to be at intermediate, high-acute, or chronic risk-for-suicide who are discharged home from the Emergency Department. All SPED eligible patients show up on the dashboard within one to three days and the Suicide Prevention Program Manager reviews the dashboard twice a week and reviews all corresponding medical records to ensure the 7-day outreach phone call was either attempted or contact was made. If the call was missed, a Suicide Prevention Coordinator will continue calls for three consecutive weeks to attempt Veteran contact. This occurs twice a week until the Veteran no longer requires the weekly phone call. Compliance will be reported to Quality, Safety, Value Board, chaired by Medical Center Director and Chief of Staff monthly until 90 percent or greater compliance is achieved and sustained for 6 consecutive months.

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 five 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 five OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the 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	• Staff complete an individual root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.
Medical Staff Privileging	• Service chiefs define time frames for Focused Professional Practice Evaluations.
Environment of Care	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Clinicians complete a Comprehensive Suicide Risk Evaluation following a positive suicide risk screen for patients seen in the Emergency Department. • Clinicians create or update a suicide safety plan for patients determined to be at intermediate, high-acute, or chronic risk-for-suicide and safe to discharge home from the Emergency Department. • Clinicians follow up within seven days with patients determined to be at intermediate, high-acute, or chronic risk-for-suicide who were discharged home from the Emergency Department.

Appendix B: Healthcare System Profile

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

Table B.1. Profile for Central Arkansas Veterans Healthcare System (598) (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	$633,287,999	$713,785,194	$817,306,419
Number of:			
• Unique patients	73,770	69,886	79,114
• Outpatient visits	939,394	856,246	884,965
• Unique employees§	2,898	2,847	2,943
Type and number of operating beds:			
• Community living center	152	152	152
• Domiciliary	154	154	154
• Medicine	140	107	107
• Mental health	60	60	60
• Residential psychiatry	25	25	25
• Surgery	40	40	40
Average daily census:			
• Community living center	105	107	71
• Domiciliary	118	93	61
• Medicine	77	78	100
• Mental health	31	27	22
• Residential psychiatry	17	12	2

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

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Average daily census cont.			
• Surgery	18	14	12

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 5, 2023

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

Subj: Comprehensive Healthcare Inspection of the Central Arkansas Veterans Healthcare System in Little Rock

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 Central Arkansas Veterans Healthcare System, Little Rock, Arkansas. 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 30, 2023

From: Director, Central Arkansas Veterans Healthcare System (598)

Subj: Comprehensive Healthcare Inspection of the Central Arkansas Veterans Healthcare System in Little Rock

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 Central Arkansas Veterans Healthcare System in Little Rock, Arkansas. I concur with the findings and recommendations in the report.
2. Central Arkansas Veterans Healthcare System remains committed to ensuring our Veterans receive exceptional health care.

(Original signed by:)

Dr. Margie Scott
Medical Center Director

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