US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

**VETERANS HEALTH ADMINISTRATION**

# Comprehensive Healthcare Inspection of the San Francisco VA Health Care System in California

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***Figure 1.*** *San Francisco VA Medical Center of the San Francisco VA Health Care System in California.*

*Source: https://www.visn21.va.gov/locations/sanfrancisco.asp.*

# Abbreviations

| | |
|---|---|
| CHIP | Comprehensive Healthcare Inspection Program |
| 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 San Francisco VA Health Care System, which includes the San Francisco VA Medical Center and multiple outpatient clinics in California. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

1. Leadership and organizational risks

2. Quality, safety, and value

3. Medical staff privileging

4. Environment of care

5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)

The OIG conducted an unannounced inspection of the San Francisco VA Health Care System during the weeks of May 2 and May 9, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders 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 Health Care System Director, Associate Director for Patient Care Services/Nurse Executive, and Chief of Staff in the following areas of review: Leadership and Organizational Risks; 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 OIG issued five recommendations for improvement to the Health Care System Director, Associate Director for Patient Care Services/Nurse Executive, and Chief of Staff. 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 Health Care System 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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Assistant Inspector General
for Healthcare Inspections

# 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 San Francisco VA Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

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

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

1. Leadership and organizational risks

2. Quality, safety, and value

3. Medical staff privileging

4. Environment of care

5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)

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[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 San Francisco VA Health Care System includes the San Francisco VA Medical Center and associated outpatient clinics in California. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from August 20, 2018, through May 12, 2022, the last day of the unannounced multiday evaluation.[5] During the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

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 Health Care System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

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[5] The OIG's last comprehensive healthcare inspection of the San Francisco VA Health Care System occurred in August 2018. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in February 2019 and opioid replacement treatment program reviews at the San Francisco VA Medical Center in February 2021 and the Oakland Behavioral Health Clinic in July 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 acting Health Care System Director (Director), Associate Director for Patient Care Services/Nurse Executive, Chief of Staff, Deputy Director, and Associate Director. The Chief of Staff and Associate Director for Patient Care Services/Nurse Executive oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for more than two and a half years. The acting Director was the appointed Deputy Director and was previously the Associate Director. The Chief of Staff was the most tenured member, assigned in March 2015. The Associate Director was the newest member of the team, joining in September 2019. To help assess the executive leaders' engagement, the OIG interviewed the acting Director, Associate Director for Patient Care Services/Nurse Executive, Chief of Staff, and Associate Director

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

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

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

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 $917,650,007 had increased by almost 11 percent compared to the previous year's budget of $830,379,858.[10] The acting Director said that leaders spent about $50 million of the budget increase on non-VA care.[11] Additionally, the acting Director stated that leaders purchased the Oakland Behavioral Health Clinic from the VA Northern California Health Care System for approximately $26 million. Lastly, the acting Director reported spending funds on service expansion at the Santa Rosa VA Outpatient Clinic.

## 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.

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

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

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

To assess employees' attitudes toward the workplace, the OIG reviewed results from VA's All Employee Survey from FYs 2019 to 2021 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[13]

## Ability to Disclose a Suspected Violation
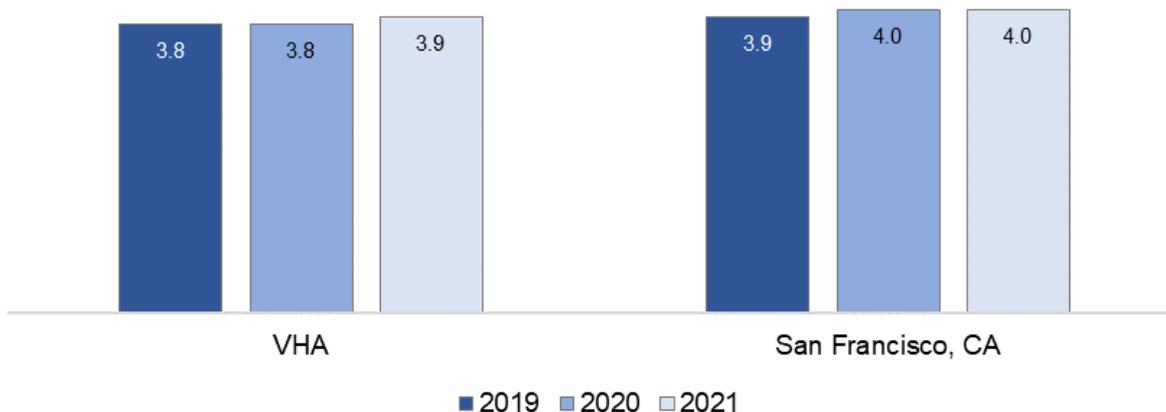


*Figure 2.* All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.

*Source: VA All Employee Survey (accessed April 4, 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

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[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 variation in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

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

[15] "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.[16]

**Inpatient Recommendation**
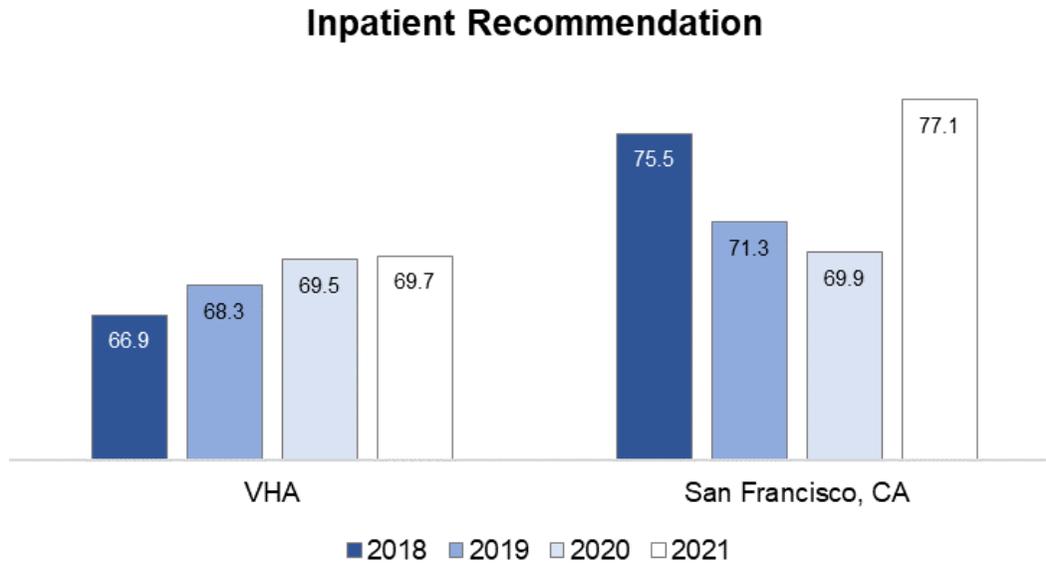


*Figure 3.* Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?

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.

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

## Outpatient Patient-Centered Medical Home Satisfaction
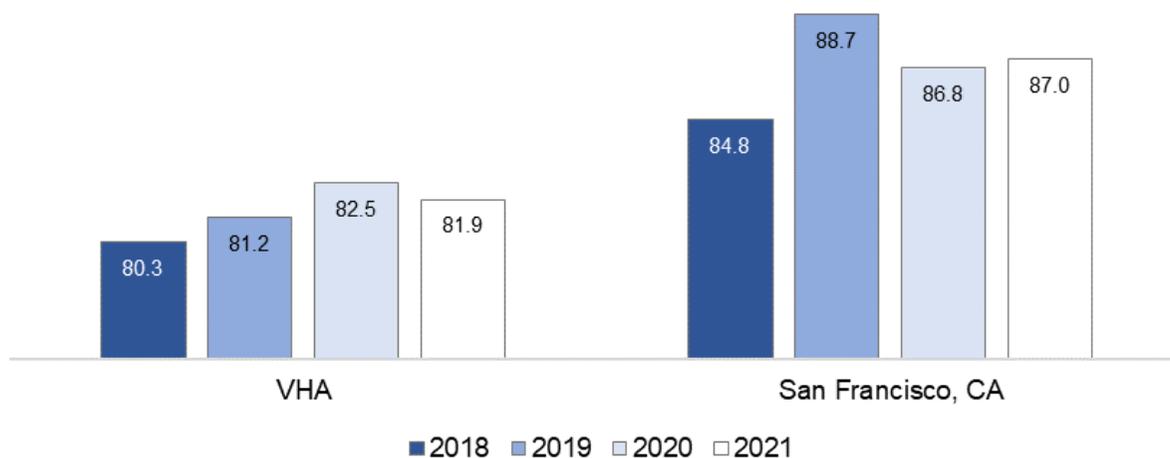


*Figure 4.* Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?

*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.*

## Outpatient Specialty Care Satisfaction
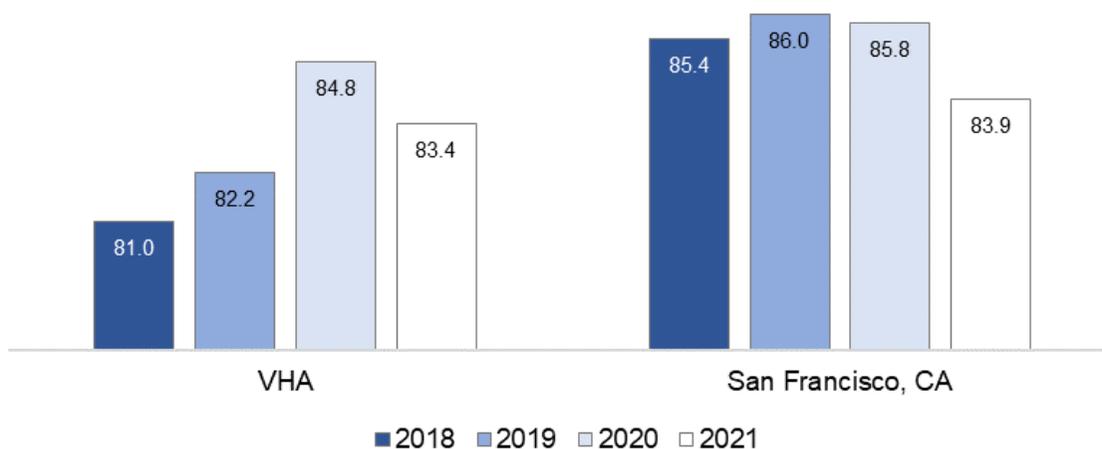


*Figure 5.* *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

*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

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[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 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 those events as well as lose trust from patients and staff.[22]

The OIG spoke with the acting Director to discuss how staff identified and reported patient safety events. The acting Director explained that leaders discussed root cause analyses and improvement efforts each business day after the morning report.[23] The acting Director also reported receiving adverse event notifications from quality management leaders at all times of the day and being called immediately if disoriented patients wandered away or patients left the facility against medical advice. The acting Director articulated that to prevent future adverse events, leaders chartered root cause analyses when patterns emerged related to patient harm and simulated live scenarios to assist staff in being better prepared. The acting Director added that the quality management leadership team had been unstable the past few years and close communication with the team would be important going forward.

The acting Chief, Quality Management stated that each morning, the quality management team reviewed patient safety events and held confidential discussions with executive leaders if needed. The acting chief also said that staff recently began conducting root cause analyses for close calls.

The Risk Manager explained that if staff identified an adverse event that may require an institutional disclosure, executive leaders reviewed the incident, along with The Joint Commission's definition of a sentinel event or VHA's guidance, to determine the correct disposition. Additionally, the Risk Manager reported placing all institutional disclosures on a quarterly institutional disclosure worksheet to ensure follow up.

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

[20] VHA Directive 1004.08.

[21] The Joint Commission, *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.

[23] 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.)

## Leadership and Organizational Risks Findings and Recommendations

VHA requires leaders to conduct an institutional disclosure when an adverse event causes or may cause the patient's death or serious injury.[24] The OIG requested adverse patient safety events that occurred from August 20, 2018, through May 1, 2022, and reviewed events reported by healthcare system staff. The OIG found that leaders did not conduct an institutional disclosure for a sentinel event that may have contributed to the patient's death. Failure to perform institutional disclosures can erode VA's core values and reduce patients' trust in the organization. A patient safety manager reported that the event was erroneously not shared with the Risk Manager to begin the institutional disclosure process.

## Recommendation 1

1. The Health Care System Director determines the reasons for noncompliance and ensures leaders conduct institutional disclosures for all applicable sentinel events.

Healthcare system concurred.

Target date for completion: March 31, 2024.

Healthcare system response: The Director evaluated and determined there were no additional reasons for noncompliance. A Patient Safety Manager and the Risk Manager will meet twice a week to review reported safety events for applicable sentinel events and determine if institutional disclosures are needed. A Patient Safety Manager will document sentinel events that were determined to need institutional disclosures (denominator) in an Excel document stored in a secure online filing location. The Risk Manager will document the completion of institutional disclosures (numerator) in an Excel document stored in a secure online filing location. The Risk Manager will calculate percent compliance, where numerator is completed institutional disclosures and the denominator is the number of sentinel events needing an institutional disclosure. These documents and the percent compliance will be monitored by the Associate Chief of Staff Quality, Safety, Value. The Associate Chief of Staff Quality, Safety, Value will report the numerator, denominator, and compliance percentage to the Quality Safety Value Board, chaired by the Director, on a quarterly basis starting August 2023 until a minimum of 90 percent compliance is maintained for six consecutive months.

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[24] VHA Directive 1004.08.

## 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."[25] 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.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[27]

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.[28] 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."[29] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[30]

Finally, the OIG assessed the healthcare system's culture of safety.[31] 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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[25] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[26] 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.)

[27] VHA Directive 1100.16.

[28] 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.

[29] VHA Directive 1190.

[30] VHA Directive 1190.

[31] 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 13, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

## Quality, Safety, and Value Findings and Recommendations

VHA requires the peer review committee to complete a final review of peer review cases and recommend "non-punitive, non-disciplinary actions to improve the quality of health care delivered."[32] Further, for cases assigned a Level 2 or 3, VHA requires the provider's supervisor to communicate the peer review committee's recommendation to the provider and "ensure that the appropriate action is implemented."[33] The OIG reviewed documentation for Level 3 peer reviews conducted from May 1, 2021, through April 30, 2022, and did not find the Peer Review Committee consistently recommended or that supervisors ensured implementation of individual improvement actions. Failure to recommend or implement related actions likely prevented improvements in the providers' patient care practices. The acting Chief, Quality Management, detailed to the position in July 2021, acknowledged the lack of a standardized process for tracking critical peer review processes and attributed this to frequent quality management staff turnover.

## Recommendation 2

2. The Health Care System Director evaluates and determines any additional reasons for noncompliance and ensures the Peer Review Committee recommends improvement actions for all Level 3 peer reviews, and supervisors ensure implementation of those actions.

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[32] VHA Directive 1190.

[33] A peer review is assigned a Level 2 when "most experienced and competent clinicians <u>might have managed the case differently but it remains within the standard of care</u>" and a Level 3 when "most experienced and competent clinicians <u>would have managed the case differently</u>." VHA Directive 1190.

Healthcare system concurred.

Target date for completion: February 29, 2024.

The Director evaluated and determined there were no additional reasons for noncompliance. The Peer Review Program Manager will ensure the Peer Review Committee's meeting minutes include the committee's recommended improvement action(s) for all Level 3 peer reviews. The Peer Review Program Manager will email the committee's recommendation(s) for improvement to the applicable provider's supervisor or service chief, monitor and track the recommendations through completion on a secure tracking log, and report the monthly status to the Peer Review Committee. The numerator is the number of Level 3 peer reviews where the supervisor for the provider completes the Peer Review Committee recommended improvement action(s). The denominator is the number of Level 3 peer reviews where the Peer Review Committee recommends improvement action(s). The Peer Review Program Manager will report the numerator, denominator, and compliance percentage quarterly to the Medical Executive Committee until a minimum of 90 percent compliance is maintained for six consecutive months. The Director reviews the Medical Executive Committee minutes, documented by the Director's signature.

VHA requires all patient safety events that receive an actual or potential safety assessment code score of 3 receive an individual root cause analysis.[34] For the period reviewed, May 1, 2021, through April 30, 2022, the Patient Safety Manager reported not completing an individual root cause analysis for one of the patient safety events with an actual or potential safety assessment code score of 3. This may limit healthcare system leaders' analyses of risks that may lead to patient harm. The acting Chief, Quality Management acknowledged a lack of oversight due to competing management priorities while overseeing multiple services.

## Recommendation 3

3. The Health Care System Director evaluates and determines any additional reasons for noncompliance and ensures the Patient Safety Manager conducts a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.

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[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 is a "ranked matrix score (3 = highest risk, 2 = intermediate risk, 1 = lowest risk)." VHA Handbook 1050.01. VHA Directive 1050.01.

Healthcare system concurred.

Target date for completion: December 31, 2023.

The Director evaluated and determined there were no additional reasons for noncompliance. The High Reliability Organization Nurse Manager and patient safety managers meet weekly to review patient safety reports including safety assessment code score 3 cases, and plan follow up actions. Plans for an individual or aggregate root cause analysis are documented in the patient safety report of the Joint Patient Safety Reporting system for all actual and potential safety assessment code scores of 3. A report from the Joint Patient Safety Report system is run monthly of all actual and potential safety assessment code scores of 3 including the patient safety report number and the corresponding individual or aggregate root cause analysis completed. The numerator is the number of actual and potential safety assessment code score of 3 events that received an individual or aggregate root cause analysis, and the denominator is the number of actual and potential safety assessment code score of 3 events. A patient safety manager will report the numerator, denominator, and compliance percentage monthly to the Medical Executive Committee until a minimum of 90 percent compliance is maintained for six consecutive months. The Director reviews the Medical Executive Committee minutes as indicated with a signature.

## 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 defines the Focused Professional Practice Evaluation as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[39] The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[40] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[41]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[42] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the Chief of Staff. VHA also requires facilities to have credentialing

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[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 Handbook 1100.19.

[41] VHA Handbook 1100.19.

[42] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[43]

The OIG interviewed key managers and selected and reviewed the privileging folders of 29 medical staff members who had a completed Focused Professional Practice Evaluation or Ongoing Professional Practice Evaluation.

## Medical Staff Privileging Findings and Recommendations

VHA requires an executive committee of the medical staff to review Ongoing Professional Practice Evaluation results for consideration in LIPs' reprivileging and document its decisions in the meeting minutes.[44] The OIG found that the Medical Executive Committee did not consistently document its decision to recommend continued privileges. Insufficient evidence to support reprivileging could adversely affect quality of care and patient safety. The Chief of Staff stated the Medical Executive Committee reviewed each LIP's Ongoing Professional Practice Evaluation; however, the discussion was unintentionally omitted from the meeting minutes.

## Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Medical Executive Committee reviews Ongoing Professional Practice Evaluation results and documents privileging decisions in the meeting minutes.

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[43] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

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

Healthcare system concurred.

Target date for completion: January 31, 2024.

Healthcare system response: The Chief of Staff evaluated and determined there were no additional reasons for noncompliance. The Medical Staff Office Credentialing and Privileging Manager will present the Professional Standards Board results of each individual re-privileging provider along with the Professional Standards Board recommendation to approve or disapprove continued privileges to the Medical Executive Committee. Based on the Ongoing Professional Practice Evaluation review and the Professional Standards Board recommendation, the Medical Executive Committee members will motion to approve or disapprove the re-privileging renewal request. The discussion and decision will be documented in the Medical Executive Committee minutes. The Medical Staff Office Credentialing and Privileging Manager will report the percentage compliance to the Medical Executive Committee, chaired by the Chief of Staff. The numerator will be the number of re-privileging providers with documented individual discussion about the provider for each month, and the denominator will be the number of re-privileging providers for each month. The Supervisory Program Analyst or designee under the Chief of Staff will monitor until 90 percent compliance is maintained for six consecutive months.

# Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[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.

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.[46] VHA 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.[47]

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:

- Dialysis unit

- Emergency department

- Intensive care unit (3rd floor, building 203)

- Medical/surgical inpatient units (3B-north, telemetry)

- Primary care clinic (medical practice/primary care)

- Women's health clinic (women's center)

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

[46] 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.

[47] 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.

## Environment of Care Findings and Recommendations

VHA requires staff to conduct comprehensive environment of care inspections at a "minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is delivered."[48] The OIG found that for FY 2021, staff did not inspect all patient care areas twice during the year and all non-patient care areas once. As a result, staff may not have been able to identify potential patient safety risks and deficiencies in a timely manner. The Chief, Environmental Services reported that comprehensive environment of care inspections were limited during the COVID-19 pandemic to allow for social distancing. The chief added they resumed full rounds in July 2021; thus, the OIG made no recommendation.

VHA requires "[e]xpiration dates on commercial products…be adhered to as they reflect product usability or stability rather than sterility of the contents."[49] The OIG found commercial sterile supplies which expired in 2018, 2020, and 2021 in the women's center supply room. The use of expired supplies may pose risks to those seeking healthcare services. The Associate Director explained that there was no process to verify staff checked and discarded supplies as needed.

## Recommendation 5

5. The Associate Director for Patient Care Services/Nurse Executive evaluates and determines any additional reasons for noncompliance and ensures staff check supply rooms for expired supplies and discard them.

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[48] VHA Directive 1608.

[49] VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016. (VHA rescinded and replaced this directive with VHA Directive 1116, *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023.)

Healthcare system concurred.

Target date for completion: January 31, 2024.

Healthcare system response: The Associate Director of Patient Care Services/Nurse Executive, the Associate Director, and Chief Supply Chain Officer (position previously titled Chief, Logistics Service) evaluated and determined that the expired supplies within the Womens Clinic were in a non-network connected Omnicell (supply dispensing cabinet) and were not electronically monitored by Supply Chain Management (service previously titled Logistics). The Womens Clinic supplies are now kept in a network connected Omnicell that is electronically monitored weekly by Supply Chain Management personnel. The current practice is to assign supply chain management personnel to each Omnicell location to perform outdated supply checks twice a week and complete the weekly checklist for each Omnicell. Any expired items are immediately removed by supply chain management personnel. A monthly audit will calculate percent compliance, where the numerator is the number of completed weekly checklists for all operational Omnicells and the denominator is the number of expected weekly checklists for all operational Omnicells. Beginning in August 2023, a monthly audit report on all operational Omnicells will be presented to the Clinical Product Review Committee. The Clinical Product Review Committee minutes will have a signed concurrence from the Chief Supply Chain Officer who will document distribution to the Associate Director of Patient Care Services/Nurse Executive every month until the audits demonstrate a 90 percent or greater compliance for six consecutive months.

## 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."[50] 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."[51]

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.[52] 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."[53] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from the emergency department or urgent care center and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 45 randomly selected patients who were seen in the emergency department or urgent care center from December 31, 2020, through August 1, 2021.

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

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

[52] 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.)

[53] 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 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 Health Care System Director, Associate Director for Patient Care Services/Nurse Executive, and Chief of Staff. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

### Table A.1. Summary Table of Recommendations

| Healthcare Processes | Recommendations for Improvement |
|---|---|
| Leadership and Organizational Risks | • Leaders conduct institutional disclosures for all applicable sentinel events. |
| Quality, Safety, and Value | • The Peer Review Committee recommends improvement actions for all Level 3 peer reviews, and supervisors ensure implementation of those actions.<br>• The Patient Safety Manager conducts a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3. |
| Medical Staff Privileging | • The Medical Executive Committee reviews Ongoing Professional Practice Evaluation results and documents privileging decisions in the meeting minutes. |
| Environment of Care | • Staff check supply rooms for expired supplies and discard them. |
| Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives | • None |

# Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 21.[1]

**Table B.1. Profile for San Francisco VA Health Care System (662)**
**(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 | $696,213,469 | $830,379,858 | $917,650,007 |
| Number of: | | | |
| • Unique patients | 71,225 | 69,567 | 82,078 |
| • Outpatient visits | 669,882 | 643,541 | 785,060 |
| • Unique employees§ | 2,681 | 2,900 | 3,039 |
| Type and number of operating beds: | | | |
| • Community living center | 120 | 120 | 85 |
| • Medicine | 53 | 53 | 53 |
| • Mental health | 0 | 0 | 0 |
| • Neurology | 12 | 12 | 12 |
| • Rehabilitation medicine | 4 | 4 | 4 |
| • Residential rehabilitation | 11 | 11 | 11 |
| • Surgery | 43 | 43 | 43 |
| Average daily census: | | | |
| • Community living center | 122 | 83 | 70 |
| • Medicine | 66 | 53 | 51 |
| • Mental health | 7 | - | - |
| • Neurology | 4 | 2 | 4 |
| • Residential rehabilitation | 13 | 6 | 3 |

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[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 | 24 | 19 | 17 |

*Source: VHA Support Service Center and VA Corporate Data Warehouse.*

*Note: The OIG did not assess VA's data for accuracy or completeness.*

*\*October 1, 2018, through September 30, 2019.*
*†October 1, 2019, through September 30, 2020.*

*‡October 1, 2020, through September 30, 2021.*

*§Unique employees involved in direct medical care (cost center 8200).*

# Appendix C: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: July 18, 2023

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

Subj: Comprehensive Healthcare Inspection of the San Francisco VA Health Care System in California

To: Director, Office of Healthcare Inspections (54CH06)

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

1. Thank you for the opportunity to respond to the draft report, Comprehensive Healthcare Inspection of the San Francisco VA Health Care System in California.

2. I have reviewed the findings and recommendations in the OIG draft report. I concur with the submitted action plans.

*(Original signed by:)*

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

# Appendix D: Healthcare System Director Comments

## Department of Veterans Affairs Memorandum

Date: July 18, 2023

From: Director, San Francisco VA Health Care System (662)

Subj: Comprehensive Healthcare Inspection of the San Francisco VA Health Care System in California

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of the San Francisco VA Health Care System in California. I concur with the findings and recommendations in the report.

2. San Francisco VA Health Care System remains committed to ensuring our Veterans receive exceptional health care.

   *(Original signed by:)*

   Jia F. Li, MBA, FACHE
   Health Care System Director
   San Francisco VA Health Care System

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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