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VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire

CHIP Report | **22-03157-95** | **March 6, 2024**

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Figure 1. *Manchester VA Medical Center in New Hampshire.*

Source: *https://www.va.gov/manchester-health-care/locations/* (*accessed March 3, 2023*).

Abbreviations

ADPCS	Associate Director, Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
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 outpatient settings of the Manchester VA Medical Center, which includes multiple outpatient clinics in New Hampshire.[1] 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 suicide prevention initiatives)

The OIG initiated an unannounced inspection of the Manchester VA Medical Center during the week of March 20, 2023. 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 medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement, including infrastructure concerns, and issued five recommendations to the Medical Center Director and Chief of Staff in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. The OIG issued an additional recommendation to the Veterans Integrated Service Network Director in the Medical Staff Privileging review area. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use

[1] The Manchester VA Medical Center does not provide inpatient care.

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. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 23.

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 25–26, 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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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 outpatient settings of the Manchester VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes.[1] The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so they can make informed decisions to improve care.[2]

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.[3] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[4]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[5]

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

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[1] The Manchester VA Medical Center does not provide inpatient care.

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

[3] 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): 13, https://doi.org/10.1136/bmjopen-2014-005055.

[4] 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.

[5] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Manchester VA Medical Center includes multiple outpatient clinics in New Hampshire. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review the week of March 20, 2023.[6] 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.[7] 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 medical center leaders complete corrective actions. The directors' 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.

[6] The OIG's last comprehensive healthcare inspection of the Manchester VA Medical Center occurred in February 2021. The Joint Commission performed ambulatory, behavioral health care and human services, and home care accreditation reviews in November 2021.

[7] 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.[8] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[9] 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.[10]

To assess this medical center's leadership and risks, the OIG considered the following 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 medical center leaders' responses
6. Infrastructure concerns

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 medical center had a leadership team consisting of the Medical Center Director (Director); Chief of Staff; Associate Director, Patient Care Services (ADPCS); Associate Director; and Chief of Quality Management. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs. At the time of the OIG inspection, the executive leadership team had worked together for approximately 13 months since the Chief of Staff started in February 2022.

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

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

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

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

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $331,395,887 increased by approximately 4 percent compared to the previous year's budget of $317,884,540.[11] The Associate Director reported spending funds on staffing, care in the community, and construction projects such as replacing heating, ventilation, and air conditioning systems and repairing the roof.[12]

The OIG noted that total patient visits during FYs 2020 through 2022 grew, but the Community Living Center admissions decreased.[13] The Associate Director and ADPCS explained the average census in the Community Living Center was much lower than the total capacity due to nursing staff challenges since the onset of the COVID-19 pandemic. The ADPCS described multiple strategies to recruit and retain nursing staff including sign-on and retention bonuses.

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 medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[15] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The medical center's scores for the selected question were similar to VHA's for all three FYs. The Director explained how strong leadership presence enhanced employee engagement and willingness to speak up. Additionally, the Director said leaders implemented weekly staff forums to communicate information and recognize staff accomplishments. The Director also described meeting new employees during orientation and discussing expectations, promoting new ideas,

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

[12] VA offers care in the community to patients when facilities are not able to provide the type of care needed. "Community Care," Department of Veterans Affairs, accessed May 3, 2023, https://www.va.gov/communitycare/.

[13] "A Community Living Center (CLC) is a VA nursing home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed April 1, 2023, https://www.va.gov/geriatrics/pages/va_community_living_centers.asp.

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

[15] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

and encouraging staff to report concerns. The ADPCS attributed employees' willingness to disclose concerns to leaders conducting safety meetings, role-modeling behavior, and answering staff questions.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Manchester VA Medical Center	3.8	3.9	3.9

Source: VA All Employee Survey (accessed November 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 assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[16] The OIG reviewed responses to two relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022.[17] Table 2 provides survey results for VHA and the medical center over time.

The medical center's scores indicated patients were satisfied with the outpatient care provided. The Associate Director described the significance of patients' first impressions, emphasized the importance of staff being approachable, and said they strive for excellent customer service. The Chief of Staff asserted that despite competition with the local medical community, patients chose to receive care at the medical center. The Chief of Quality Management reported leaders assigned a patient advocate to assist patients with navigating the community care process.

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

[17] The medical center does not have inpatient medical/surgical beds and therefore had no inpatient survey results.

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
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?**	82.5	89.0	81.9	85.3	81.7	87.5
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?**	84.8	90.2	83.3	88.7	83.1	89.3

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8, 2022).

**The response average is the percent of "Very satisfied" and "Satisfied" responses.*

Identified Factors Related to Possible Lapses in Care and Medical Center 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.[18] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[19] 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 and risk losing trust from patients and staff.[20]

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[18] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[19] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. 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, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

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

"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)."[21] 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 recourse."[22] 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."[23] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[24]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. The Patient Safety Manager explained the distinction between adverse and sentinel events and described referencing Joint Commission standards to determine when an adverse event met criteria for a sentinel event. The Risk Manager reported one institutional disclosure and no large-scale disclosures in FY 2022 but articulated the medical center's process for conducting a large-scale disclosure.

Infrastructure Concerns

The OIG noted several areas were closed for repair during the inspection week. The Director informed the OIG that they had faced significant infrastructure failures since 2017. The Director explained that in November 2022, extensive water damage occurred in the medical center from a pipe that weakened and burst, which caused flooding in multiple areas. The Associate Director and Chief of Staff described damage to four floors in the medical center and reported that the operating room and laboratory were still inoperable. The Associate Director added that patients received laboratory services in the outpatient clinics, community laboratories tested the specimens, and the medical center's laboratory staff reviewed the results. The Chief of Staff explained the operating room would likely remain closed for the remainder of the year but described plans to resume gastrointestinal procedures in late March 2023, using space in the

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[21] 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.

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

[23] VHA Directive 1004.08.

[24] 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. The new directive contains similar language regarding patient safety as the rescinded handbook.)

Urgent Care Center, and said other surgical procedures would be initiated in a few months using leased space in an off-site ambulatory surgical center.

The Associate Director reported that as of the week of the OIG's inspection, two floors remained closed due to ongoing repairs, and leaders had moved clinics multiple times to support patient care. The Associate Director also discussed plans to resume surgical services that were delayed due to the lack of a national contracting process for obtaining emergency leases and acknowledged receiving assistance from the VISN and VA Central Office with leasing an off-site ambulatory surgical center location. The Director commended the staff's resilience in adapting to and overcoming multiple barriers created from this serious event.

The Director further described inclement weather in February 2023 that caused flooding in the recently renovated Urgent Care Center, a newly constructed mental health area in the medical center, and the Tilton community-based outpatient clinic. The Director said the Tilton clinic reopened for patient care on March 22, 2023, but the affected areas at the medical center remained under renovation during the inspection week.

The Associate Director explained the building was very old and built on a fault line. The Associate Director added that leaders completed a seismic replacement application for FY 2025 with the goal of obtaining a new building by FY 2031.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations but was concerned about the negative effects of infrastructure limitations on the medical center's ability to meet the needs of the veterans it serves.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[25] To achieve this goal, VHA requires that its medical facility leaders 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.[27]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing medical center vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[28] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[29]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[30] 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 assessments of care" that consistently contribute to quality management efforts at the individual provider level.[32]

The OIG team interviewed key managers and reviewed relevant documents.

Quality, Safety, and Value Findings and Recommendations

During the inspection's review period, VHA required the patient safety manager to communicate patient safety events to facility leaders "within 24 hours during the weekday and 72 hours over weekend and holidays."[33] The OIG found the Patient Safety Manager did not report patient safety events to facility leaders as required in FY 2022. When adverse events are not promptly reported, it may limit leaders' awareness and delay their identification of quality of care and

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

[26] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[27] VHA Directive 1100.16.

[28] VHA Handbook 1050.01; VHA Directive 1050.01.

[29] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[30] 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.

[31] VHA Directive 1190.

[32] VHA Directive 1190.

[33] VHA National Center for Patient Safety, *Guidebook for JPSR [Joint Patient Safety Reporting] Business Rules and Guidance*, November 2021.

patient safety process improvements. The Patient Safety Manager described checking the Joint Patient Safety Reporting system daily and alerting leaders when events involved potential, probable, or immediate harm, or after identifying trends that needed immediate attention, and reported believing this met the requirement.[34] Because VHA updated the Joint Patient Safety Reporting *Guidebook* in December 2022, allowing the patient safety manager to determine the "appropriate…report type and frequency" of safety event communication to leaders, the OIG did not issue a recommendation.[35]

[34] "JPSR [Joint Patient Safety Reporting system] is a user-based web application for front-line VHA users which means that all and any events types are captured in the JPSR system." VHA National Center for Patient Safety, *Guidebook for JPSR [Joint Patient Safety Reporting] Business Rules and Guidance.*

[35] VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, December 2022.

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 an LIP 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 under the chief of staff. VHA also requires facilities to have credentialing and

[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.

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 29 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

In carrying out its responsibilities under the Inspector General Act, the OIG is authorized to have timely "access to all records, reports, audits, reviews, documents, papers, recommendations, or other material" related to the agency's programs and operations.[43] The OIG requested specific documentation in November 2022 to determine whether facility staff complied with selected privileging requirements for LIPs. Staff provided the OIG with no privileging documentation for 8 LIPs and incomplete or inaccurate documentation for the remaining LIPs. This impeded the OIG's ability to efficiently meet its oversight obligations. The Chief of Staff reported being unaware of the November 2022 documentation request. The Chief of Quality, Safety, and Value reported being aware of the missing documentation but believing the former Credentialing and Privileging Manager was responsible for providing the requested documentation and acknowledged not escalating the concern to the Chief of Staff or Director.

During the inspection week, the OIG team began evaluating the previously requested documents and noted that while some documentation was missing, service chiefs and credentialing and privileging staff were able to provide many of the documents throughout the week. The OIG remains concerned that staff did not initially provide the requested documents but did not issue a recommendation since they provided them during the inspection week.

VHA requires an executive committee of the medical staff to review results of professional practice evaluations.[44] The OIG did not find evidence to support the Medical Executive Council's review of professional practice evaluation results for some LIPs.[45] The council's failure to review evaluation results may lead to LIPs providing care without a full evaluation of their clinical competence, which could jeopardize patient safety. For one LIP, the acting Chief of Medicine reported the FPPE was ongoing; however, the OIG received documentation the FPPE had been completed. In another case, the Chief of Staff reported being unaware the LIP had privileges approved in both primary care and compensation and pension and acknowledged failing to evaluate the LIP for the primary care privileges prior to reprivileging. For an LIP

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[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] IG Act § 406(a)(1)(A).

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

[45] The Medical Executive Council is this medical center's executive committee of the medical staff.

privileged in sleep medicine, the acting Chief of Medicine reported the practitioner had no related patient encounters during the evaluation period.

Recommendation 1

1. The Chief of Staff ensures the Medical Executive Council reviews results of professional practice evaluations.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Medical Center's Medical Executive Council (MEC) will open and review each provider's professional practice evaluation and document the review in the Medical Executive Council minutes. The Medical Executive Council minutes will be audited for 6 consecutive months to demonstrate >90% compliance ensuring a review of professional practice evaluation results. Compliance progress will be reported out monthly to the Quality, Safety, & Value Committee.

VHA requires practitioners with equivalent specialized training and similar privileges to complete professional practice evaluations.[46] The OIG did not find documentation that similarly trained and privileged practitioners completed some professional practice evaluations. This resulted in LIPs practicing without a comprehensive evaluation, potentially causing specific practice deficiencies to be unidentified, which may pose patient safety risks. The Chief of Staff acknowledged completing one evaluation due to initial challenges locating an external reviewer, using documentation from conferences and peer reviews to assist with determining the LIP's competence. Additionally, the Chief of Staff reported being unaware a nurse practitioner evaluated a physician. This is a similar finding from a prior comprehensive healthcare inspection.[47]

Recommendation 2

2. The Chief of Staff ensures practitioners with equivalent specialized training and similar privileges complete licensed independent practitioners' professional practice evaluations.

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[46] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," May 18, 2021; VHA Directive 1100.21(1).

[47] VA OIG, *Comprehensive Healthcare Inspection of the Manchester VA Medical Center, New Hampshire*, Report No. 19-00040-10, November 25, 2019.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Medical Center's Credentialing and Privileging office will ensure all professional practice evaluation forms include fields for training (e.g. MD, DO, NP, PA) as well as specialty (e.g. Cardiology, Neurology, Urology). The Compliance Department will audit 100% of the Professional Practice Evaluations until 6 consecutive months of >90% compliance with the requirement that practitioners with equivalent specialized training and similar privileges complete licensed independent practitioners' chart review. The audit denominator will be the total professional practice evaluations during that month with numerator defined as those professional practice evaluations completed by practitioners with equivalent training and similar privileges. Compliance progress will be reported out monthly to the Quality, Safety, & Value Committee.

VHA requires the FPPE process to "be defined in advance, using objective criteria accepted by the LIP."[48] The OIG found no evidence LIPs consistently accepted the FPPE criteria in advance. When LIPs are unaware of the criteria used to evaluate their performance, they may not understand FPPE expectations during this critical initial performance period. The Chief of Staff reported the former Credentialing and Privileging Manager prepared documentation outlining FPPE criteria and routed it to the service chiefs to be reviewed and signed by the LIPs; however, due to competing priorities, this may not have occurred prior to the LIPs beginning patient care. This is also a similar finding from a prior comprehensive healthcare inspection.[49] The OIG did not make a recommendation but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

VHA requires the VISN chief medical officer to oversee the privileging process at medical facilities within the network.[50] Based on the prior and current inspection findings, the OIG was concerned about VISN oversight of privileging processes. This may have resulted in the medical center's privileging program continuing to be deficient in their procedures. The VISN Quality Management Officer reported the VISN only assisted with finding peer evaluators at other facilities but acknowledged an opportunity to improve the process.

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

[49] VA OIG, *Comprehensive Healthcare Inspection of the Manchester VA Medical Center, New Hampshire*.

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

Recommendation 3

3. The Veterans Integrated Service Network Director ensures the Veterans Integrated Service Network Chief Medical Officer provides oversight of the medical center's privileging process.

Veterans Integrated Service Network concurred.

Target date for completion: September 30, 2024

Veterans Integrated Service Network response: The VISN Chief Medical Officer (CMO) provides regular oversight in the privileging process, including weekly one on one meetings with the Chief of Staff (COS), weekly Chief of Staff calls including all COS across the VISN, reviewing the results of each facility's Credentialing & Privileging Facility Self-Assessment (FSA) and a yearly site visit focused solely on the Credentialing and Privileging process for the site. VISN Credentialing & Privileging Officer meets with Credentialing & Privileging Managers weekly and the full group monthly. CMO, Deputy Chief Medical Officer (DCMO) and Credentialing and Privileging (C&P) Officer ensured that all sites completed their Facility Self-Assessments (FSA) this year and created an action plan. The VISN C&P Officer attended the debriefs for each site where their leadership was made aware of any deficiencies and action plans. The VISN will show continued oversight by providing a summary of the FSA findings to the VISN Healthcare Delivery Council (HDC) and a follow up of Action Plan completion 90 days after the presentation. In addition, the VISN will complete a site visit focused on Credentialing and Privileging for each site where FSA results and current review of the C&P program are validated and discussed. Oversight will be documented in the minutes of the HDC meetings and in the presentations by the C&P Officer at site visits.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[51] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[52]

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 inspected 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.[53]

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

- Community Living Center
- Primary care clinic (Sunapee Primary Care)
- Urgent Care Center

Environment of Care Findings and Recommendations

VHA requires facility leaders to have a comprehensive environment of care program, which includes staff conducting environmental 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."[54] Additionally, VHA requires the comprehensive environment of care coordinator to schedule physical inspections and maintain the records.[55] The OIG reviewed the FY 2022 environmental

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[51] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[52] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[53] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

[54] VHA Directive 1608.

[55] VHA Directive 1608.

inspections reports and found staff did not inspect some clinical areas at least twice, which could have prevented them from proactively identifying unsafe conditions.[56] The Administrative Officer/Environment of Care Coordinator reported assuming the environment of care coordinator duties in November 2021 and acknowledged inadvertently failing to ensure staff completed documentation for all inspected areas. The coordinator added that water damage from flooding resulted in multiple clinical areas being relocated, which caused challenges for accurately maintaining documentation of the areas requiring inspection.

Recommendation 4

4. The Medical Center Director ensures the Comprehensive Environment of Care Coordinator or designee schedules environment of care inspections and staff complete and document them at the required frequency.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: Beginning in fiscal year 2024 (10/1/2023) the Comprehensive Environment of Care Coordinator created and published the entire fiscal year's schedule for Comprehensive Environment of Care inspections. This schedule defines the required frequency of inspections for each clinical and non-clinical area. The Comprehensive Environment of Care Coordinator also provided real-time education and training to members of the Comprehensive Environment of Care team on the Performance Logic software platform used to document Comprehensive Environment of Care inspections. Each member of the Comprehensive Environment of Care team completes and submits their documentation directly within the Performance Logic software which is also used to verify attendance. Performance Logic reports will be audited for 6 consecutive months demonstrating >90% compliance for required comprehensive environment of care inspections that are conducted twice a year for clinical areas and annually for non-clinical areas. Compliance progress will be reported out monthly to the Environment of Care Committee.

VHA requires staff to ensure a clean and safe environment.[57] In all three locations inspected, the OIG observed unsecured sharps containers (used for disposal of needles and other sharp objects) and expired supplies. These conditions increase the risk of contamination and pathogen exposure. The Logistics Manager said staff were unable to enter the Community Living Center

[56] The OIG found staff did not inspect all clinical locations twice in FY 2022, including Building 1, basement: Radiology; first floor: Laboratory, Mental Health, Pharmacy Service, and Primary Care; second floor: Laboratory; fourth floor: Same Day Surgery; Building 15, second floor: Respiratory.

[57] VHA Directive 1608.

to check for outdated supplies during the pandemic, and the movement of clinic locations due to water damage disrupted supply storage spaces.

Recommendation 5

5. The Medical Center Director ensures staff keep patient care areas clean and safe.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: Unsecured sharps containers and expired items were removed the week of March 20, 2023, during the survey. All support services have full access to the Community Living Center. Logistics & Environmental Management Services audit for expired items & secured waste containers during Comprehensive Environment of Care Inspections via Performance Logic. Performance Logic reports will be audited for 6 consecutive months, demonstrating >90% compliance with logistics affirming line item “Are supplies within expiration date” & Environmental Management Services affirming line item “Are regulated medical waste and/or biohazard containers properly labeled, stored, and secured” during Comprehensive Environment of Care Inspections. Compliance will be reported out monthly at Environment of Care Committee.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[58] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[59] The suicide rate for veterans was higher than for nonveteran adults during 2020.[60] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[61]

Due to the prevalence of suicide among at-risk veterans, VHA implemented 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.[62] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[63]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[64]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 48 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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[58] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[59] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

[60] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[61] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[62] 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.)

[63] 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)." Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[64] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

In ambulatory care settings, VHA requires designated staff to complete a suicide risk evaluation following a positive suicide risk screen. VHA also states that staff should complete the evaluation on the same calendar day unless it is “not logistically feasible or clinically appropriate,” such as in situations where patients need urgent or emergent care.[65] In these situations, after assuring the patient’s safety, staff should complete the evaluation within 24 hours.[66] The OIG estimated staff did not complete the Comprehensive Suicide Risk Evaluation on the same calendar day for 30 (95% CI: 17 to 43) percent of patients with a positive screen in situations appropriate for same-day evaluations, which is statistically significantly above the OIG’s 10 percent deficiency benchmark.[67] Additionally, the OIG observed that for the patients without evaluations on the same day as the positive screen, some did not receive the evaluation within 24 hours. Failure to complete the evaluation in a timely manner poses a safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The Chief of Mental Health and Chief of Primary Care reported low staffing levels left less time for providers to complete evaluations, so they did not always complete them the same calendar day. In addition, the Suicide Prevention Coordinator stated staff used inconsistent processes to obtain same-day mental health services for patients, and patients were sometimes unwilling to wait to be evaluated by a mental health provider following the primary care visit.

Recommendation 6

6. The Medical Center Director ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

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[65] 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.”

[66] 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.”

[67] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The suicide prevention coordinators, with the assistance of the VISN, have implemented a real time report that is checked twice a day for any positive suicide risk screens without a corresponding Comprehensive Suicide Risk Evaluation. The suicide prevention team will audit 100% of positive Columbia screens to ensure same-day completion of the suicide risk comprehensive evaluation for 6 consecutive months, demonstrating >90% compliance to the Medical Center's Quality, Safety, & Value Committee.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided six recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines six OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Medical Center Director, Chief of Staff, and Veterans Integrated Service Network Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• The Medical Executive Council reviews results of professional practice evaluations. • Practitioners with equivalent specialized training and similar privileges complete licensed independent practitioners' professional practice evaluations. • The Veterans Integrated Service Network Chief Medical Officer provides oversight of the medical center's privileging process.
Environment of Care	• The Comprehensive Environment of Care Coordinator or designee schedules environment of care inspections and staff complete and document them at the required frequency. • Staff keep patient care areas clean and safe.
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

Appendix B: Medical Center Profile

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

Table B.1. Profile for Manchester VA Medical Center (608) (October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$289,858,207	$317,884,540	$331,395,887
Number of: • Unique patients	25,763	27,066	29,469
• Outpatient visits	261,463	281,772	265,299
• Unique employees§	761	773	770
Type and number of operating beds: • Community living center	112	112	28
Average daily census: • Community living center	21	14	16

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, 2019, through September 30, 2020.*

† October 1, 2020, through September 30, 2021.

‡October 1, 2021, through September 30, 2022.

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

[1] VHA medical facilities are classified according to a complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships,* February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 14, 2024

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire

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

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

Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire.

I have reviewed and concur with the recommendations, findings, and action plans set forth in this report.

(Original signed by:)

Ryan Lilly, MPA
Network Director
VA New England Healthcare System

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 9, 2024

From: Director, Manchester VA Medical Center (608)

Subj: Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire

To: Director, VA New England Healthcare System (10N1)

The Manchester VA Medical Center would like to thank the Office of Inspector General team for their review. I have reviewed the report from the Comprehensive Healthcare Inspection Program conducted March 21, 2023 - March 23, 2023, and concur with the recommendations and submitted action plans.

(Original signed by:)

Kevin M. Forrest, FACHE
Medical Center Director

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