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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina

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Figure 1. *Charles George VA Medical Center in Asheville, North Carolina. Source: https://www.va.gov/asheville-health-care/locations/ (accessed March 7, 2023).*

Abbreviations

ADPCS	Associate Director Patient Care Services/Nurse Executive
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 Charles George VA Medical Center, which includes multiple outpatient clinics in North Carolina. 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 Charles George VA Medical Center during the week of April 3, 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 and issued five recommendations to the Director in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; and Mental Health. 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 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. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 20.

VA Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 22–23, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 1 and 4 closed. 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 inpatient and outpatient settings of the Charles George VA Medical Center 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 medical center 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 suicide prevention initiatives)

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

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014): 13, 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 (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Charles George VA Medical Center includes multiple outpatient clinics in North Carolina. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review the week of April 3, 2023.[5] During the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline 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 medical center leaders complete corrective actions. The Executive 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.

[5] The OIG's last comprehensive healthcare inspection of the Charles George VA Medical Center occurred in May 2021. The Joint Commission performed hospital, behavioral health, and home care accreditation reviews in February 2020.

[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 organization's 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 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

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 Director, Chief of Staff, Associate Director Patient Care Services (ADPCS)/Nurse Executive, Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

The executive leadership team had worked together since February 2022, when the Assistant Director assumed the role. However, the Director had been in the position since 2018 and the ADPCS since 2003.

[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.

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director 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 $586,574,447 decreased by approximately 2 percent compared to the previous year's budget of $596,484,077.[10] Despite the decrease, the Director acknowledged the FY 2022 budget was adequate. The Director said executive leaders were actively involved in the operation and budget decision-making process. The Associate Director reported leaders spent FY 2022 funds on staffing; equipment such as hospital beds, surgical instruments, anesthesia machines, and medical carts; and construction projects including operating room expansion, community living center improvements, and heating, ventilation, and air conditioning unit upgrades in some specialty patient care areas.[11] The Associate Director also stated service chiefs were responsible for developing annual business plans to identify projected staffing, contracting, and supply needs.

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 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.[13] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The medical center's scores were higher than VHA averages over all three years. The Director stated the medical center was consistently ranked in the top three best places to work within VHA and attributed the higher scores to frequent leader visits to staff areas and communication during safety forums. The Director also reported leaders actively participated in new employee orientation to discuss expectations, address concerns, and encourage staff to report inappropriate behavior to supervisors. The Chief of Staff described how leaders created a culture of trust and

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

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

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

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

echoed the Director's emphasis on the importance of leader visits with staff to discuss concerns. The ADPCS described how leaders promoted psychological safety by creating a culture where staff were comfortable reporting safety concerns and presenting innovative ideas. The Associate Director stated executive leaders sent handwritten thank you notes to staff for being transparent when reporting errors. The Assistant Director added leaders recognized the importance of addressing and resolving minor issues with staff, so they were willing to bring forward more significant concerns.

The ADPCS highlighted recognition from the VHA Office of Nursing Service for achieving designation again from the American Nurses Credentialing Center's Pathway to Excellence program in FY 2022.[14] The ADPCS also reported believing many new nurses chose employment at the medical center due to its reputation even though community hospitals offered lucrative signing bonuses.

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
Charles George VA Medical Center	4.1	4.1	4.1

Source: VA All Employee Survey (accessed November 22, 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.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

The medical center consistently scored higher in patient satisfaction than VHA. The Director said staff valued feedback and reported sharing patient comments with them weekly. The

[14] The Pathway to Excellence Program is a "premier designation" awarded to healthcare environments that demonstrate nursing excellence and satisfaction. "Overview of the ANCC Pathway to Excellence Program," American Nurses Credentialing Center, accessed May 8, 2023, https://www.nursingworld.org/organizational-programs/pathway/overview/.

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

Associate Director added that when patients expressed concerns, executive leaders contacted them directly by telephone to discuss the issue.

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
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	85.7	69.7	86.3	68.9	85.6
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	88.9	81.9	87.5	81.7	89.9
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	91.0	83.3	87.8	83.1	88.1

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

**The response average is the percent of "Definitely yes" responses.*

†*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.[16] According to The Joint Commission's standards for leadership, a culture of safety and continual process

[16] 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/.

improvements lead to safe, quality care for patients.[17] 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.[18]

"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)."[19] 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."[20] 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."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[22]

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 Risk Manager/Peer Review Coordinator identified 16 institutional disclosures that occurred in FY 2022 but no large-scale disclosures. The Chief of Quality Management stated the Patient Safety Manager reported adverse events daily to leaders. The Chief of Staff reported involving service chiefs in the institutional disclosure process to enhance their understanding of the importance of service

[17] The Joint Commission, *Standards Manual*, E-dition, January 20, 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.

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

[19] 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.

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

[21] VHA Directive 1004.08.

[22] 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.)

recovery and explained that when errors occurred, transparency was essential.[23] The Deputy Chief of Staff added that leaders apologized to patients and family members for adverse events that required institutional disclosures and facilitated any needed follow-up care.

The OIG team discussed the results of the prior comprehensive healthcare inspection with the Chief of Quality Management, who explained staff will request closure for the remaining open recommendation, which relates to interfacility transfers, after six months of data showing compliance. The Associate Director also explained that in February 2023, executive leaders started a new transport service to facilitate interfacility transfers to community hospitals for those patients requiring further specialized care, which involved purchasing two vehicles, hiring paramedics and emergency medical technologists, and training staff.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[23] VHA defines service recovery as one of the fundamental elements of customer service and a process involving staff's ability to quickly identify concerns, communicate resolution actions, and "turn a potentially negative experience into a positive one" for veterans, families, beneficiaries, caregivers, and survivors. VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[24] 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.[25] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[26]

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 system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[27] 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.[28]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[29] 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."[30] 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.[31]

The OIG team interviewed key managers and staff and reviewed relevant documents.

Quality, Safety, and Value Findings and Recommendations

VHA uses the National Center for Patient Safety's Joint Patient Safety Reporting system to capture real-time incident data throughout the VA system. VHA requires the patient safety manager to complete the "date investigation started" field in the reporting system for sentinel events to allow staff to track investigation completion.[32] The OIG found the Patient Safety

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

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

[26] VHA Directive 1100.16.

[27] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[29] 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.

[30] VHA Directive 1190.

[31] VHA Directive 1190.

[32] VHA National Center for Patient Safety, *Guidebook for JPSR [Joint Patient Safety Reporting] Business Rules and Guidance,* November 2021. (VHA replaced this guidebook with VHA National Center for Patient Safety, *JPSR Guidebook*, December 2022.)

Manager did not consistently complete the start date field as required for sentinel events that occurred in FY 2022. Additionally, the Patient Safety Manager did not document the date investigations were completed. Without the start and end dates entered, staff have no way to track events for a timely investigation, which could delay their identification of needed patient safety process improvements. The Patient Safety Manager reported believing the system entry generated the start date but acknowledged not tracking the number of days investigations took to complete, despite monitoring each case.

Recommendation 1

1. The Director ensures the Patient Safety Manager documents start dates for sentinel event investigations in the Joint Patient Safety Reporting system.[33]

Medical center concurred.

Target date for completion: Completed

Medical center response: Based on the VHA National Center for Patient Safety Guidebook (Guidebook), all Joint Patient Safety Report (JPSR) events require an investigation start date. On May 1, 2023, the Patient Safety Manager began entering start dates for all JPSR events (to include Sentinel Event investigations) into the JPSR system as required. To assure compliance with the Guidebook, the Patient Safety Manager reported all JPSR event start dates (to include Sentinel Event investigations) to the Quality, Safety, Value Council starting on May 1, 2023. Reporting included the numerator as the number of event investigations' start dates entered (to include Sentinel Event investigations) and the denominator as the total number of all JPSRs entered. The Patient Safety Manager reported data monthly to the Quality, Safety, Value Council since May 1, 2023. The Director, who chairs the Quality, Safety, Value Council, ensures adherence to this requirement by evaluating monthly reports from the Patient Safety Manager to the Quality, Safety, Value Council. As of May 1, 2023, the start dates for 100% of JPSR events (to include all Sentinel Event investigations) have been entered into the JPSR system.

VHA requires the patient safety manager to initiate root cause analyses for events with a potential or actual safety assessment code score of 3.[34] The OIG found the Patient Safety Manager did not consistently initiate a root cause analysis for applicable adverse events. When

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

[34] VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*; VHA National Center for Patient Safety, *JPSR Guidebook.* A root cause analysis is a "comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." A safety assessment score is "assigned to a patient safety event utilizing a matrix that takes into account both the severity and probability of harm. The matrix is used to generate a risk score of 1, 2 or 3 (1=Lowest Risk; 2=Intermediate Risk; 3=Highest Risk)." VHA Handbook 1050.01; VHA Directive 1050.01.

patient safety events are not thoroughly reviewed, it may limit leaders' awareness of system vulnerabilities that could lead to patient harm. The Patient Safety Manager described collaborating with executive leaders to determine whether to conduct a root cause analysis or consider another type of action. The Patient Safety Manager reported believing that conducting alternate methods of evaluating the event met the requirement despite being aware that root cause analyses were required.

Recommendation 2

2. The Director ensures the Patient Safety Manager initiates a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.

Medical center concurred.

Target date for completion: April 1, 2024

Medical center response: Based on the VHA National Center for Patient Safety Guidebook (Guidebook), VHA requires the Patient Safety Manager to initiate root cause analyses (RCA) for events with a potential or actual safety assessment code score of 3 (SAC 3). Beginning May 1, 2023, the Patient Safety Manager began monitoring Joint Patient Safety Reports (JPSR) to ensure completion of RCAs for potential or actual SAC 3 events. Beginning in May 2023, the Patient Safety Manager provided status updates to the Quality, Safety, Value Council. The results of the actions taken and compliance since May 2023 will be reported in February 2024 to the Quality, Safety, Value Council, the report will include one table reflecting all actual or potential SAC 3 events eligible to be included in annual aggregate RCAs and a second reflecting all actual or potential SAC 3 events with individual RCAs initiated. The Director, who chairs the Quality, Safety, Value Council, ensures adherence to this requirement by evaluating monthly reports from the Patient Safety Manager to the Quality, Safety, Value Council. The compliance goal of 90% has been met since May 1, 2023.

Medical Staff Privileging

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

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

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation 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.[39]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[40] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

[35] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Directive 1100.20.

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

The OIG interviewed key managers and selected and reviewed the privileging folders of 30 medical staff members who underwent initial privileging or reprivileging during FY 2022.[42]

Medical Staff Privileging Findings and Recommendations

VHA requires leaders to consolidate all credentialing and privileging activities at each facility into one credentialing and privileging office under the chief of staff, with the credentialing and privileging manager reporting directly to the chief of staff.[43] The OIG found staff aligned under the ADPCS completed the nursing credentialing functions, while staff reporting directly to the Deputy Chief of Staff, including the Credentialing and Privileging Manager, completed all other credentialing functions. These program office structural deviations can result in a lack of standardized credentialing and privileging oversight. The Chief of Staff and ADPCS were aware of the requirements but reported believing their process was effective.

Recommendation 3

3. The Director ensures executive leaders consolidate all credentialing and privileging activities into one credentialing and privileging office under the Chief of Staff.

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

[42] The OIG reviewed the files of 9 initially privileged and 21 reprivileged LIPs.

[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."

Medical center concurred.

Target date for completion: April 1, 2024

Medical center response: Beginning May 1, 2023, the facility began the process of program review to meet the requirements of the Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo dated December 16, 2020 "Credentialing and Privileging Staffing Modernization Efforts – Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020." The Executive Office Organizational Chart was updated on December 1, 2023, to reflect the changes to meet the memo requirements and signed by the Director. Reporting of progress is being reported monthly to Quality, Safety, Value Council. Two additional credentialing staff have been recruited and attended New Employee Orientation on February 13, 2024, with credentialing and privileging training scheduled to be completed by April 1, 2024. All credentialing and privileging functions will then be performed under the Chief of Staff office on April 1, 2024. The Director, who chairs the Quality, Safety, Value Council, ensures completion of these requirements by evaluating monthly reports from Credentialing and Privileging to the council. The action for this recommendation remains in progress.

Recommendation 4

4. The Director ensures the Credentialing and Privileging Manager reports directly to the Chief of Staff.[44]

Medical center concurred.

Target date for completion: Completed

Medical center response: On December 1, 2023, credentialing and privileging was realigned under the Chief of Staff on the Executive Office Organizational Chart. The Credentialing and Privileging Manager began reporting directly to the Chief of Staff on December 1, 2023, as required by the Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo dated December 16, 2020 "Credentialing and Privileging Staffing Modernization Efforts – Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020." Reporting of progress and completion was provided monthly to Quality, Safety, Value Council. The Director, who chairs the Quality, Safety, Value Council, ensured completion of this requirement by evaluating monthly reports from Credentialing and Privileging to the council. Facility requests closure of this recommendation based on evidence provided.

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

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."[45] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[46]

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.[47]

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

- Community Living Center
- Emergency Department
- Medical/surgical inpatient unit (5 West)
- Mental health inpatient unit (5 East Warriors Recovery Unit)
- Primary care clinic (Primary Care 3)
- Surgical Intensive Care Unit

Environment of Care Findings and Recommendations

The OIG made no recommendations.

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[45] 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.)

[46] 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.

[47] 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 (CLC)*, 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.)

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[48] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[49] The suicide rate for veterans was higher than for nonveteran adults during 2020.[50] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[51]

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.[52] 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.[53]

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.[54]

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 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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

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

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

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

[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] 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.)

[54] 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 the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen. Staff should complete the evaluation on the same calendar day unless it is "not logistically feasible or clinically appropriate," such as situations where urgent or emergent care is needed.[55] In these situations, once staff confirm patient safety, they should complete the evaluation within 24 hours of the positive screen.[56] The OIG estimated that staff did not complete the evaluation for 68 (95% CI: 54 to 80) percent of patients who had a positive screen, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[57] Failure to complete an evaluation poses a safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The Suicide Prevention Coordinator stated many patients declined the evaluation on the date of a positive screen and also reported believing there was no way to document the refusal on the evaluation template. The Assistant Chief, Primary Care acknowledged providers may not have understood the requirements despite training and lacked experience completing the evaluations.

Recommendation 5

5. The 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.

[55] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" 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)."

[56] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

[57] 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: June 30, 2024

Medical center response: The Suicide Prevention Coordinator, through the Chief of Mental Health, will report monthly to Quality, Safety, Value Council the Comprehensive Suicide Risk Evaluation (CSRE) Adherence Rate from Office of Mental Health and Suicide Prevention (OMHSP) Combined National suicide prevention metrics (RiskID). Reporting includes the numerator (number of CSRE Adherence Rate) and the denominator (number of Veterans who screened positive on the Columbia-Suicide Severity Rating Scale (CSSRS)). As of May 1, 2023, we have implemented four new actions to improve adherence of same day CSRE completion. The first action identifies evaluations not completed same day as positive screens, and these are monitored daily by Suicide Prevention staff who then send clinical staff same day reminders to complete the CSRE. The second action added was implementing a process of sending a Microsoft Teams message for handoff for positive CSSRS to Primary Care Mental Health Integration (PCMHI) staff to complete the CSRE same day. For the third action, the facility implemented an alert that immediately displays when the medical record is opened which alerts providers of a positive CSSRS and provides instructions on how to complete the pending CSRE same day. Lastly, Suicide Prevention Coordinators place a Joint Patient Safety Report for any missed CSRE following a positive CSSRS. The Director, who chairs the Quality, Safety, Value Council, ensures adherence to this requirement by evaluating monthly reports from Suicide Prevention Coordinators through the Chief of Mental Health that 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. Actions have been ongoing for six months. CSRE screens have maintained 100% compliance in October, November, and December 2023. The facility will continue to monitor compliance and submit supporting evidence once six consecutive months of 90 percent or greater is achieved.

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 five 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 five OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the 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	• The Patient Safety Manager documents start dates for sentinel event investigations in the Joint Patient Safety Reporting system. • The Patient Safety Manager initiates a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.
Medical Staff Privileging	• Executive leaders consolidate all credentialing and privileging activities into one credentialing and privileging office under the Chief of Staff. • The Credentialing and Privileging Manager reports directly to the Chief of Staff.
Environment of Care	• None
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 mid-high complexity (1c) affiliated medical center reporting to VISN 6.[1]

Table B.1. Profile for Charles George VA Medical Center (637)
(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	$493,995,245	$596,484,077	$586,574,447
Number of:			
• Unique patients	46,171	47,295	49,498
• Outpatient visits	591,434	708,566	672,903
• Unique employees§	1,835	1,931	1,889
Type and number of operating beds:			
• Hospital	103	103	103
• Community living center	73	73	73
• Domiciliary	14	14	14
Average daily census:			
• Hospital	59	66	67
• Community living center	46	40	45
• Domiciliary	6	5	7

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 "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center 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 12, 2024

From: Director, VA Mid-Atlantic Health Care Network (15N6)

Subj: Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina

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

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina.
2. I have reviewed and concur with the OIG recommendations and the action plans submitted by the Charles George VA Medical Center. As we remain committed to ensuring our Veterans receive exceptional care, VISN 6 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.

(Original signed by:)

Jonathan Benoit
for Paul S. Crews, MPH, FACHE

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 6, 2024

From: Executive Director, Western North Carolina VA Health Care System (637/11)

Subj: Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina

To: Director, VA Mid-Atlantic Health Care Network (15N6)

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina.
2. I have reviewed and concur with the recommendations and will ensure the actions to correct the findings are completed and sustained as described in the responses. I appreciated the opportunity for this review as a continuing process to improve the care to our Veterans.

   (Original signed by:)

   Stephanie Young

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