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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico

CHIP Report | 23-00100-55 | January 25, 2024

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Figure 1. *San Juan VA Medical Center of the VA Caribbean Healthcare System in Puerto Rico.*

Source: https://www.va.gov/caribbean-health-care/locations/san-juan-va-medical-center/ (accessed December 14, 2023).

Abbreviations

ADPCS	Associate Director for Patient Care Services
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 VA Caribbean Healthcare System, which includes the San Juan VA Medical Center and multiple outpatient clinics in Puerto Rico and the US Virgin Islands. 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 VA Caribbean Healthcare System 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 healthcare system'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 did not issue recommendations for improvement related to the areas reviewed for this report. The lack of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system.

VA Comments

The Veterans Integrated Service Network Director and the Healthcare System Director concurred with the report (see appendixes B and C, pages 20-21, for the full text of the directors' comments).

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

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

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

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on 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 VA Caribbean Healthcare System includes the San Juan VA Medical Center and multiple outpatient clinics in Puerto Rico and the US Virgin Islands. General information about the healthcare system can be found in appendix A.

The OIG inspected the VA Caribbean Healthcare System during the week of April 3, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

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 VA Caribbean Healthcare System occurred in March 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in July 2022, and a laboratory review in February 2023.

[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 healthcare system'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 healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Deputy Director, and Associate Director for Operations. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the deputy director position had been vacant for two months, but the permanent Associate Director was covering the position in an acting capacity. The rest of the executive team had worked together for over two years, with the newest member of the team, the Chief of Staff, assigned in February 2021. The most tenured leaders, the Associate Director and ADPCS, had served in their roles since July and August 2015, respectively.

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

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

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

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

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $806,942,390 had increased by approximately 5 percent compared to the previous year's budget of $766,383,593.[10] The Director discussed using the funds to expand Home Based Primary Care teams and establish a Whole Health program.[11] The Chief of Staff explained leaders used some of the increased budget to help retain physicians through pay increases and recruit them by offering relocation incentives and education loan reimbursement. The Chief of Staff also reported purchasing a generator and emergency water supply and reinforcing the medical center's foundation to make it compliant with earthquake resiliency standards. The ADPCS described using the increased funds to renovate the Emergency Department and modernize the Community Living Center bathrooms to accommodate wheelchairs.

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 healthcare system over time.

The healthcare system's averages were similar to VHA averages. The Director and acting Deputy Director attributed the scores to modeling high-reliability organization principles and

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

[11] "Home Based Primary Care is health care services provided to Veterans in their home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed December 18, 2023, https://www.va.gov/geriatrics/pages/Home_Based_Primary_Care.asp. VA's Whole Health approach centers around staff focusing on getting to know patients and what matters to them. "Whole Health," Department of Veterans Affairs, accessed December 18, 2023, https://www.va.gov/wholehealth/.

[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.

creating an employee engagement coordinator position.[14] Both leaders explained the high-reliability organization principles included leaders increasing visibility around the medical center and holding townhalls and patient safety forums. The acting Deputy Director added that the employee engagement coordinator met with staff and leaders to discuss and develop action plans to improve the scores. The ADPCS emphasized engaging with staff and educating them on the importance of reporting potential and actual issues.

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
VA Caribbean Healthcare System	3.8	3.8	3.7

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 healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

The healthcare system's inpatient satisfaction survey scores indicated patients were more satisfied with the care they received compared to VHA patients nationally. The Director attributed the scores to employees clearly understanding the mission and making patients feel welcomed. The Chief of Staff and the acting Deputy Director highlighted committed providers, many of whom graduated from the healthcare system's physician residency program where they received on-site training. The acting Deputy Director also identified the facility's cleanliness as a factor contributing to patient satisfaction. The ADPCS added that nursing staff were engaged

[14] "A high-reliability organization (HRO) is an organization with a goal of achieving 'zero harm' in an environment where accidents are expected due to complexity or risk factors." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

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

with patients, and during the COVID-19 pandemic, they assisted them with technology that allowed them to see and communicate with family members.

The healthcare system's primary care survey scores indicated patient satisfaction increased in FY 2022. The Director and Chief of Staff discussed expanding integrated mental health into primary care at some of the community-based clinics, allowing care teams to provide services for depression, anxiety, post-traumatic stress syndrome, and substance use without patients needing a separate appointment with mental health providers.[16]

Specialty care scores revealed an overall decline in patient satisfaction. The Director, acting Deputy Director, and Chief of Staff stated decreased patient satisfaction was due to provider vacancies in several clinics, which led to increased wait times and lack of available appointments. To address the access to care issues, the Chief of Staff discussed recruiting additional providers, technicians, and case managers. The ADPCS added that decreased satisfaction in primary and specialty care was also due to the pandemic, when appointments were virtual, and patients preferred to be seen in person.

[16] "PC-MHI [Primary Care-Mental Health Integration] works with your Patient Aligned Care Team (PACT) to meet your mental health needs right in primary care." "Patient Care Services," Department of Veterans Affairs, accessed December 18, 2023, https://www.patientcare.va.gov/primarycare/PCMHI.asp.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	83.0	69.7	83.7	68.9	84.2
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	81.9	81.9	79.6	81.7	83.4
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	81.2	83.3	69.1	83.1	69.2

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 Healthcare System Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[18] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[17] 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/.

[18] The Joint Commission, *Standards Manual*, E-dition, July 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.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[19]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[20] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[21] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[22] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[23]

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. When the OIG asked about patient safety processes, the Director and ADPCS stated staff use the Joint Patient Safety Reporting system to report events, adding that leaders meet daily with quality management and patient safety staff to review the incidents.[24] The Director also said patient safety staff track each event until staff implement all action items.

The Chief of Staff described daily huddles with the Patient Safety Manager to discuss patient safety events and stated quality management staff also review each event and recommend further evaluation as needed, such as a peer review or root cause analysis.[25] For events requiring a

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

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

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

[22] VHA Directive 1004.08.

[23] 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.)

[24] "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[25] 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. 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." VHA Directive 1050.01.

disclosure, the Chief of Staff said quality management staff coordinate the follow-up actions. The acting Quality Manager added that quality management staff and leaders collaborated to determine which events were disclosed, the type of disclosures conducted, and when adverse events should be classified as sentinel events.

The OIG discussed the results of the prior comprehensive healthcare inspection with the acting Quality Manager and Patient Safety Manager.[26] The acting Quality Manager acknowledged two recommendations, related to Disruptive Behavior Committee meeting attendance and prevention and management of disruptive behavior training, remained open but reported staff were working to achieve and sustain compliance for both.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[26] VA OIG, *Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico*, Report No. 21-00270-04, October 26, 2021.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[27] 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.[28] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[29]

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.[30] 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.[31]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care. Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[32] 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.[33]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed 24 deaths that occurred within 24 hours of inpatient admission during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

[27] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[28] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.
[29] VHA Directive 1100.16.
[30] VHA Handbook 1050.01; VHA Directive 1050.01.
[31] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.
[32] VHA Directive 1190.
[33] VHA Directive 1190.

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."[34] 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."[35]

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.[36] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[37]

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.[38]

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.[39] 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 a credentialing and

[34] 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.)

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[40]

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.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[40] 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.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of 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."[41] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[42]

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.[43]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 11 patient care areas:

- Blind rehabilitation inpatient unit
- Community Living Centers 1 and 2
- Emergency Department
- Intensive care units (medical and cardiac)
- Medical/surgical inpatient units (6-J and 6-K)
- Primary care clinic
- Spinal cord injury inpatient unit
- Women's health clinic

[41] 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.)

[42] 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.

[43] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 6, 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, *Standards for Community Living Centers*, October 5, 2023.)

Environment of Care Findings and Recommendations

The OIG made no recommendations.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[44] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[45] The suicide rate for veterans was higher than for nonveteran adults during 2020.[46] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[47]

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.[48] 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.[49]

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.[50]

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

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

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

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

[48] 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.)

[49] 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.)

[50] 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

The OIG made no recommendations.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and did not issue recommendations for improvement. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

Appendix A: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 8.[1]

Table A.1. Profile for VA Caribbean Healthcare System (672) (October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$705,199,825	$766,383,593	$806,942,390
Number of:			
• Unique patients	58,880	62,356	62,709
• Outpatient visits	990,559	1,112,749	1,046,401
• Unique employees§	3,519	3,630	3,538
Type and number of operating beds:			
• Community living center	122	122	122
• Medicine	158	158	158
• Mental health	30	30	30
• Rehabilitation medicine	20	20	20
• Spinal cord	20	20	20
• Surgery	40	40	40
Average daily census:			
• Community living center	81	61	62
• Medicine	107	102	99
• Mental health	22	17	20
• Rehabilitation medicine	10	11	12
• Spinal cord	15	13	13

[1] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "with high volume, high risk patients, most complex clinical programs, and large 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.

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census, cont.:			
• Surgery	11	10	12

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

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

*****October 1, 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).*

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 3, 2024

From: Director, VA Sunshine Healthcare Network (10N8)

Subj: Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico

To: Director, Office of Healthcare Inspections (54CH02)

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

I have reviewed the VAOIG's report of the Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System and concur. Thank you for your thoughtful and thorough review of system operations. I appreciate the OIG's partnership in ensuring Veterans receive worldclass healthcare.

(Original signed by:)

David B. Isaacks, FACHE

Appendix C: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: January 3, 2024

From: Director, VA Caribbean Healthcare System (672)

Subj: Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico

To: Director, VA Sunshine Healthcare Network (10N8)

Thank you for your review of the VA Caribbean Healthcare System. I have reviewed the report and concur as written. The staff and leadership of the VA Caribbean Healthcare System take great pride in serving our Veterans.

(Original signed by:)

Carlos R. Escobar, FACHE

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