DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the El Paso VA Health Care System in Texas

CHIP REPORT | REPORT #22-00043-39 | JANUARY 12, 2023

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Figure 1. *El Paso VA Health Care System in Texas.*
Source: https://www.va.gov/el-paso-health-care/.

Abbreviations

ADPCS/NE	Associate Director for Patient Care Services/Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the outpatient settings of the El Paso VA Health Care System, which includes multiple outpatient clinics in New Mexico and Texas. 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 that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

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

The OIG conducted an unannounced virtual inspection of the El Paso VA Health Care System from January 10 through January 18, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement and issued three recommendations to the System Director and Chief of Staff in the following areas of review: Quality, Safety, and Value and

[1] The OIG did not perform this review at the El Paso VA Health Care System because the system does not have an emergency department or urgent care center.

Medical Staff Privileging. These results are detailed throughout the report and summarized in appendix A on page 20.

Conclusion

The OIG issued three recommendations for improvement to the System Director and Chief of Staff. The number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and System 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 will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the outpatient settings of the El Paso VA Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

[3] Danae 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 address these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

[5] The OIG did not perform this review at the El Paso VA Health Care System because the system does not have an emergency department or urgent care center.

Methodology

The El Paso VA Health Care System also provides care through associated outpatient clinics in New Mexico and Texas. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from May 6, 2019, through January 18, 2022, the last day of the unannounced multiday evaluation.[6] During the virtual 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.[7] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

[6] The OIG's last comprehensive healthcare inspection of the El Paso VA Health Care System occurred in May 2019. The Joint Commission performed ambulatory, behavioral health care and human services, and home care accreditation reviews in April 2021.

[7] Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[8] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their vision and strategy, and "practice systems thinking and collaboration across boundaries."[9] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[10]

To assess this healthcare system's leadership and risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 2 illustrates this healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the System Director, Associate Director, Chief of Staff, and Associate Director for Patient Care Services/Nurse Executive (ADPCS/NE). The Chief of Staff and ADPCS/NE oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for approximately six months. The System Director had served in the role since 2016, followed by the ADPCS/NE, who had been in the position since March 2020. The Chief of Staff and Associate Director were assigned in July 2021. To help assess the executive leaders' engagement, the OIG interviewed

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

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

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

the System Director, Chief of Staff, ADPCS/NE, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

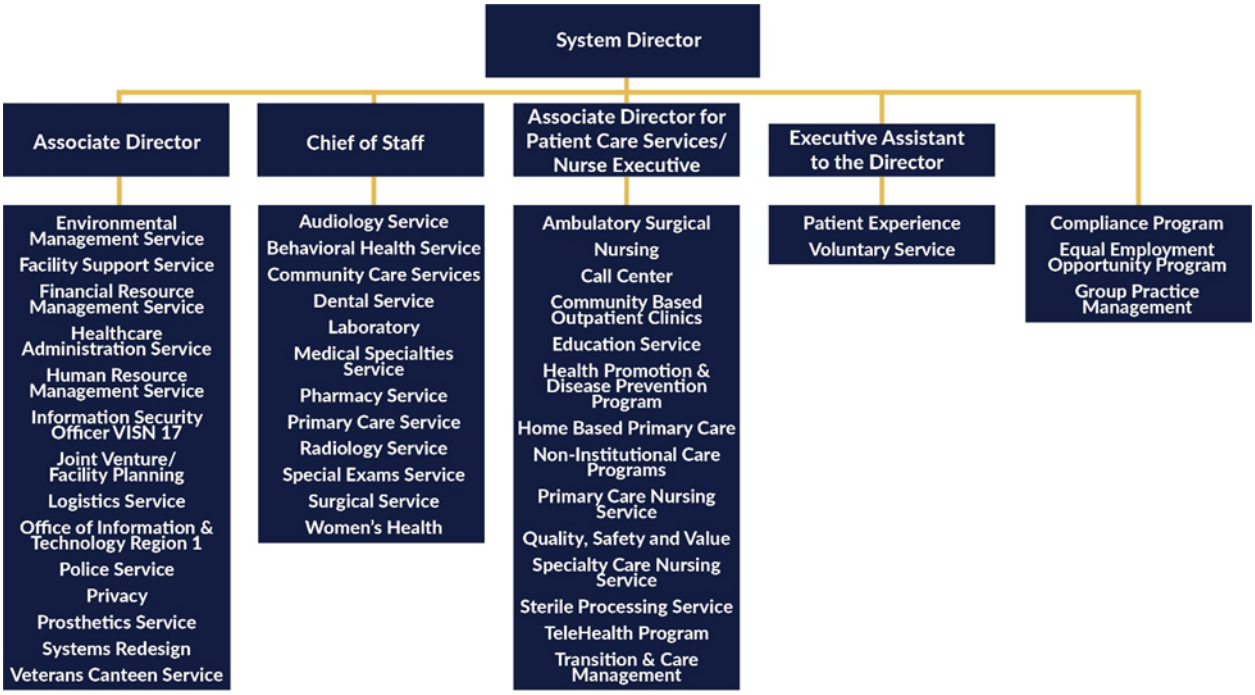

Figure 2. *Healthcare system organizational chart.*
Source: El Paso VA Health Care System (received January 10, 2022).

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $443,228,404 had increased by about 11 percent compared to the previous year's budget of $398,736,066.[11] The Associate Director reported an increase in community care dollars from $29 million in 2020 to about $40 million in 2021. Leaders reported believing they spent a significant portion of the budget on care in the community.

The System Director and Associate Director reported that leaders opened a new community-based outpatient clinic as part of a space improvement project and purchased needed equipment around the same time. The System Director also described recent accomplishments that included opening a Central Wellness Center; bringing the Sleep Lab in-house; and hiring gastroenterology and anesthesia providers, as well as support staff.

The System Director reported that funding for the new William Bowman replacement facility was granted. The new facility, which was in the design phase at the time of the inspection, would

[11] VHA Support Service Center (VSSC).

encompass about 500,000 square feet plus a 100,000 square foot add-on for dialysis, home health, or nursing home services.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] The instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

To assess employee attitudes toward healthcare system leaders and the workplace, the OIG reviewed results from VHA's All Employee Survey from FYs 2019 to 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[13] The OIG found that healthcare system averages for the selected survey question were similar to VHA averages. The scores for the leaders were similar to or higher than the system and VHA averages, except for the ADPCS/NE's score in 2019. The ADPCS/NE attributed the improvement to believing in high reliability principles, being a safety-strong facility, executive leaders and employees regularly visiting patient care areas together, and working to gain employees' respect. In addition, the Chief of Staff reported that safety stories are shared during the morning report and at service chiefs' staff meetings, and all managers completed the Management by Strengths survey.[14]

[12] "AES Survey History, Understanding Workplace Experiences in VA," VSSC website.

[13] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only. The 2019, 2020, and 2021 All Employee Survey results are not reflective of employee satisfaction with the current Chief of Staff and Associate Director, who assumed their roles after the surveys were administered. The 2019 All Employee Survey results are not reflective of the current ADPCS/NE, who was permanently assigned in 2020.

[14] The Management By Strengths program works with companies to improve relationships between staff and customers. "Management By Strengths," MBS [Management By Strengths], Inc., accessed April 14, 2022, https://strengths.com.

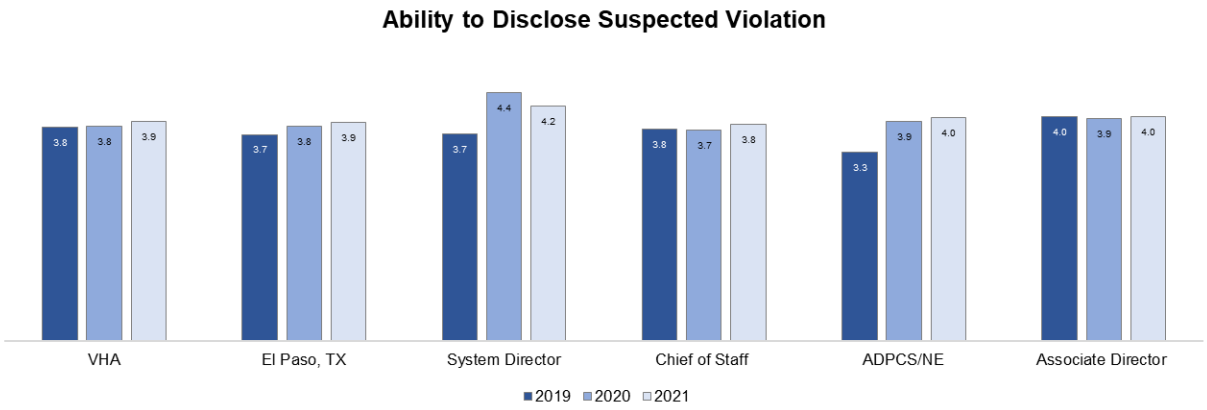

Figure 3. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed December 6, 2021).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.[15]

VHA also collects Survey of Healthcare Experiences of Patients data from Patient-Centered Medical Home (primary care) and Specialty Care surveys.[16] The OIG reviewed responses to two relevant survey questions that reflect patient experiences with the healthcare system from October 1, 2017 (FY 2018), through August 31, 2021. Figures 4 and 5 provide survey results for VHA and the healthcare system over time.[17]

The healthcare system's patient satisfaction survey results for outpatient primary and specialty care consistently reflected lower scores than the VHA averages. The System Director reported believing the scores reflected past leaders' lack of engagement, in addition to a decrease in primary care and behavioral health leaders. The System Director added that employees recognize that current leaders were more engaged than previous leaders. The ADPCS/NE described a consistent increase in hiring primary care providers after engaging the VISN's support. The Chief of Staff reported believing the scores reflected employees not owning performance measures related to their work areas and not being involved in the performance improvement process.

[15] "Patient Experiences Survey Results," VSSC website.

[16] "Patient Experiences Survey Results," VSSC website.

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

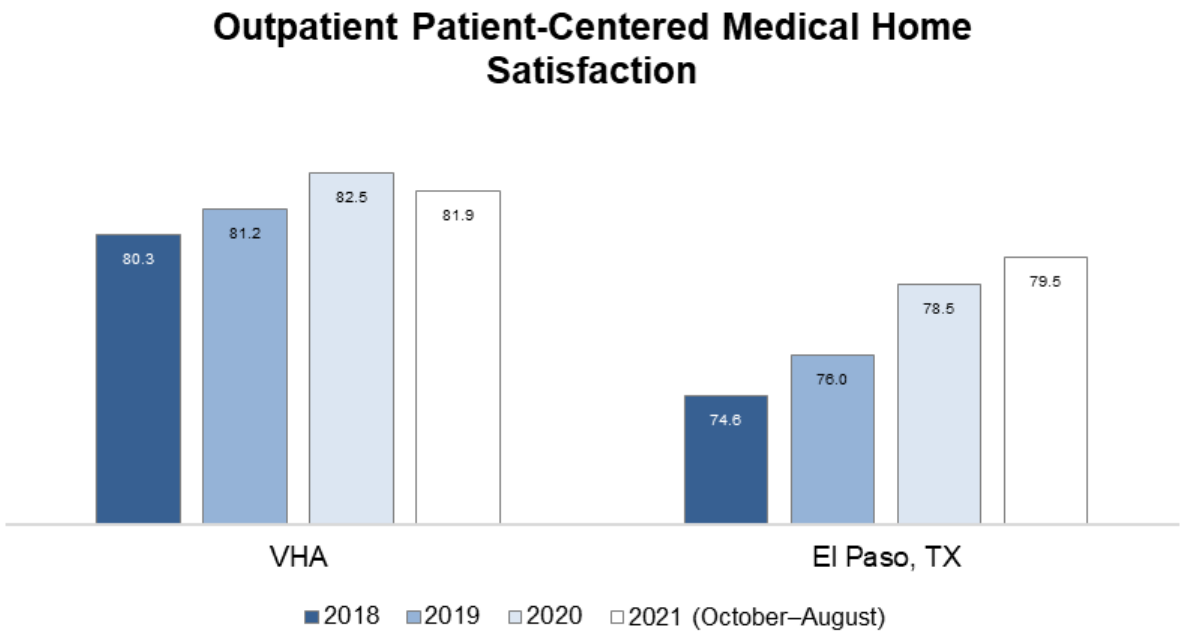

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 2021).

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

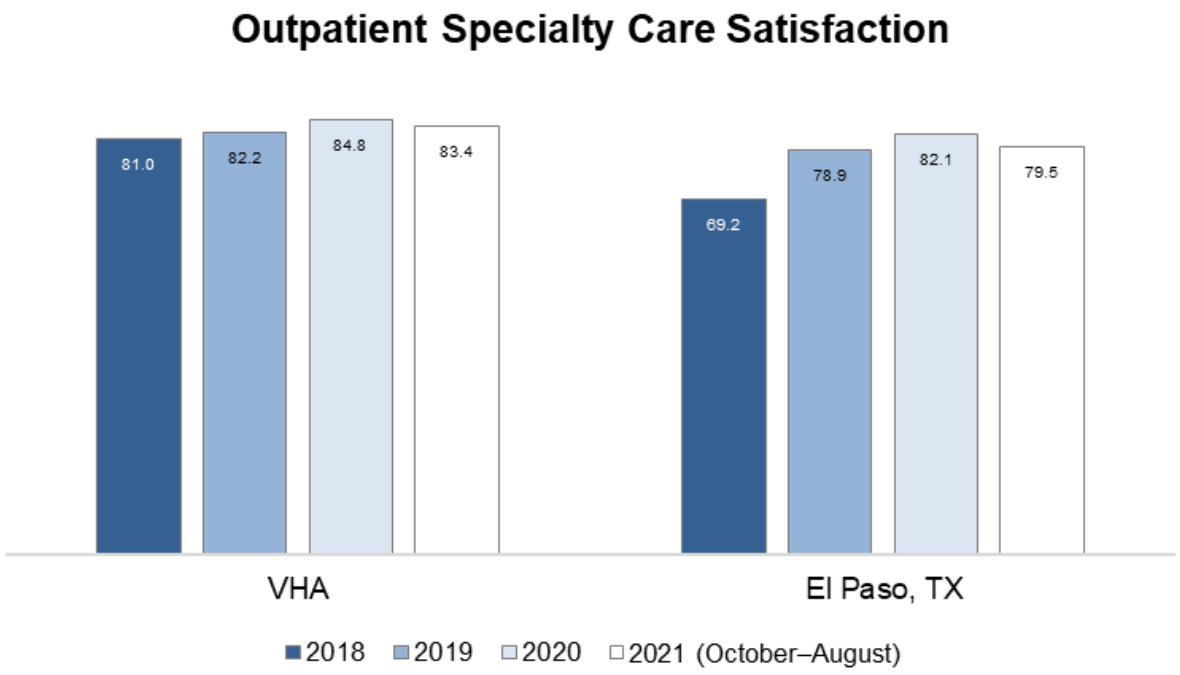

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 2021).

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

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

Leaders must ensure that patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[18] VHA defines a sentinel event as an incident or condition that "results in death, permanent harm, or severe temporary harm and [where] intervention [is] required to sustain life."[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

[18] Frankel, *A Framework for Safe, Reliable, and Effective Care;* "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[19] 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.

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.

The OIG requested adverse patient safety events that occurred from May 6, 2019 (the prior OIG CHIP site visit), through January 10, 2022. The Risk Manager reported that the system did not have any sentinel events or institutional or large-scale disclosures during this time frame.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's (TJC's) standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[22] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events, as well as lose trust from patients and staff.[23]

The System Director described creating a psychologically safe environment, where employees feel safe reporting adverse events, as the number one priority. In addition, the System Director explained the process employees used to report unsafe events and indicated that all events were reviewed by staff from the appropriate service-line level through the executive-leader level. The System Director further discussed being notified of adverse events immediately through face-to-face contact or via telephone. The System Director added that staff used the root cause analysis process to review events to mitigate future occurrences. Furthermore, the System Director expressed that they had a robust Systems Redesign Program, adopted Lean Six Sigma principles, and all employees became White Belt certified during new employee orientation.[24]

[21] VHA Directive 1004.08.

[22] The Joint Commission, Standards Manual, E-dition, July 1, 2022. TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (This directive was rescinded and replaced by VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

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

[24] Six Sigma methodology uses data to drive process improvement and decrease waste. "What is Six Sigma?," The Council for Six Sigma Certification, accessed December 5, 2022, https://www.sixsigmacouncil.org/six-sigma-definition/. A person with a White Belt certification has demonstrated basic knowledge of the Six Sigma methodology, history, and knowledge of the process. "Six Sigma White Belt Certification," The Council for Six Sigma Certification, accessed March 21, 2022, https://www.sixsigmacouncil.org/.

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG inspection, the executive team had worked together for about six months. The OIG's review of employee survey data indicated that staff felt they were able to safely disclose suspected violations. Patient experience survey data revealed opportunities for leaders to improve patients' perception of outpatient primary and specialty care services. The System Director attributed the lower scores to a decrease in primary care and behavioral health leaders, among other things. The ADPCS/NE described the hiring of more primary care providers after receiving support from the VISN. The OIG made no recommendations.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[25] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain TJC accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from TJC).[27]

To determine whether VHA facilities have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system's committee responsible for oversight of healthcare operations and its ability to review data and ensure that key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[28] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[29] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[30]

Finally, the OIG assessed the healthcare system's culture of safety.[31] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

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

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

[26] VHA Directive 1100.16.

[27] VHA Directive 1100.16.

[28] A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[29] VHA Directive 1190.

[30] VHA Directive 1190.

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

Quality, Safety, and Value Findings and Recommendations

VHA requires all patient safety events that receive an actual or potential safety assessment code score of three to receive an individual root cause analysis or be included in an aggregated review.[32] The OIG reviewed seven patient safety events with an actual or potential safety assessment code score of three and did not find evidence that staff completed a root cause analysis or included the event in an aggregate review for two of them. One of the events involved a VA provider who ordered a diagnostic test but did not communicate the results in a timely manner, which may have contributed to the patient's death. The second event was a delay in care and treatment.

When a patient safety event does not have a thorough review, leaders may be limited in their analysis of system vulnerabilities that can lead to patient harm. The Risk Manager and Chief [of] Quality, Safety and Value reported that the adverse event resulting in a patient's death did not occur at the facility, so staff did not complete a root cause analysis. For the second patient safety event, the Risk Manager stated that leaders only performed a management review because of quality of care concerns.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures the Patient Safety Manager conducts a root cause analysis or includes the patient safety event in an aggregate review for all events assigned an actual or potential safety assessment code score of three.

[32] Adverse events, actual or close calls, are scored based on the severity of the event and how often the event occurs using a one to three scale. The event is assigned a ranked matrix score (3 = highest risk, 2 = intermediate risk, 1 = lowest risk). VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

Healthcare system concurred.

Target date for completion: May 31, 2023

Healthcare system response: The Director reviewed and did not identify any additional reasons for noncompliance. The Patient Safety Manager will ensure that a Root Cause Analysis or an Aggregate Review is performed for each adverse event assigned an actual or potential Safety Assessment Code score of three monthly. Starting November 1, 2022, the Patient Safety Manager will begin ongoing monitoring by utilizing a spreadsheet to track the completion of Root Cause Analyses and aggregate reviews resulting from an actual or potential Safety Assessment Code score of three. The six-month consecutive period for ongoing monitoring will be from November 1, 2022, to April 30, 2023, to ensure sustained compliance. The Patient Safety Manager will report the compliance rate monthly to the Quality, Safety, and Value Board. The facility target for compliance is 90 percent. The numerator will be the number of root cause analyses and aggregate reviews completed for all adverse events with a Safety Assessment Code score of three and the denominator will be the total number of Patient Safety events assigned an actual or potential Safety Assessment Code score of three.

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."[33] 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."[34]

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.[35] LIPs are granted clinical privileges for no more than two years and must be reprivileged prior to their expiration.[36]

VHA defines the Focused Professional Practice Evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[37] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[38] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation (OPPE) 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 and aligned under the Chief of Staff. VHA also requires facilities to have credentialing

[33] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (The credentialing portion of this handbook was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)
[34] VHA Handbook 1100.19.
[35] VHA Handbook 1100.19.
[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.

and 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 several medical staff members:

- Six solo/few practitioners who underwent clinical privileging or reprivileging in the previous 12 months[42]
- Seven LIPs who had an FPPE completed in the previous 12 months
- Twenty LIPs who were reprivileged in the previous 12 months

Medical Staff Privileging Findings and Recommendations

VHA requires the Chief of Staff to ensure "another practitioner at the facility with equivalent specialized training and similar privileges as the practitioner being evaluated completes the FPPE/OPPE review."[43] The OIG found that one solo practitioner's FPPE lacked evidence that another practitioner with similar training and privileges completed the evaluation. As a result, the practitioner continued to deliver care without a thorough evaluation of clinical competencies, which could have jeopardized quality of care and patient safety. The Chief of Staff reported not being on staff at the healthcare system when the evaluation was completed and thus could not provide a reason for noncompliance. However, the Chief of Staff confirmed the service chief involved no longer worked at the facility.

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

[42] VHA refers to a solo practitioner as being one provider in the facility who is privileged in a particular specialty. VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners," August 29, 2016. (This memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on December 18, 2020. The December 18, 2020, memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on May 18, 2021). The OIG considers a few practitioners as being two providers in the facility who are privileged in a particular specialty.

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

Recommendation 2

2. The Chief of Staff determines the reasons for noncompliance and ensures that practitioners with similar training and privileges complete Focused Professional Practice Evaluations of licensed independent practitioners.

Healthcare system concurred.

Target date for completion: April 30, 2023

Healthcare system response: The Chief of Staff reviewed and did not determine any additional reasons for noncompliance. The Credentialing & Privileging Chief hired an analyst on June 6, 2022, to assist with the reviewing of completed Focused Professional Practice Evaluations. The analyst competency was assessed on September 2, 2022. The Chief Credentialing & Privileging provided training to all services on March 17, 2022, to highlight that all Focused Professional Practice Evaluation reviews must be completed by a provider with similar training and privileges. Additionally, the Chief Credentialing & Privileging will conduct monthly monitoring for providers with similar training and privileges that conducted Focused Professional Practice Evaluations for licensed independent practitioners to ensure the facility meets its target of 90 percent compliance for six consecutive months. The numerator will be the number of Focused Professional Practice Evaluations reviewed by a similarly trained and privileged provider. The denominator will be the total number of Focused Professional Practice Evaluations sent for external review. The Chief Credentialing & Privileging will present the compliance results monthly to the Privileging & Credentialing committee, which the Chief of Staff chairs.

VHA requires that results of OPPEs be documented in the practitioner's profile and reviewed by an executive committee of the medical staff for consideration in LIPs' reprivileging. VHA also requires the committee's decisions to be documented in meeting minutes.[44] The OIG found that for all 22 OPPEs reviewed (including those for two solo practitioners), the Clinical Executive Board (this system's executive committee of the medical staff) did not review each individual practitioner's OPPE or other required information. As a result, the Clinical Executive Board granted privileges without a thorough review of the practitioners' relevant OPPE activities. The Chief, Credentialing and Privileging reported that the board's privileging process involved reviewing by service line, not individual practitioners.

[44] VHA Handbook 1100.19.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Clinical Executive Board reviews and recommends licensed independent practitioners for reprivileging based on individual practitioners' Ongoing Professional Practice Evaluations and documents its decisions in meeting minutes.

Healthcare system concurred.

Target date for completion: April 30, 2023

Healthcare system response: The Chief of Staff reviewed and did not determine any additional reasons for noncompliance. The full name of each provider that is undergoing re-privileging is now documented in the Credentialing & Privileging Committee minutes as of February 9, 2022. The Credentialing & Privileging Chief or analyst will track completed reviews monthly to ensure all providers undergoing re-privileging are presented to the committee monthly and all required elements are documented. The numerator is the number of individual practitioners' Ongoing Professional Practice Evaluations reviewed by the Clinical Executive Board. The denominator is the number of Ongoing Professional Practice Evaluation reviews due. The target rate of compliance is a minimum of 90 percent. The Chief Credentialing & Privileging will present the compliance rate to the Privileging & Credentialing committee monthly, which the Chief of Staff chairs.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[45] The physical environment of a healthcare organization must not only be functional but should also promote healing.

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid-related. This was an increase from 56,064 in the previous 12 months.[46] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times in emergencies and contribute to a safe healthcare environment.[47]

The OIG team interviewed managers and staff and reviewed relevant documents related to the healthcare system's environment of care.[48]

Environment of Care Findings and Recommendations

The OIG made no recommendations.

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

[46] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," accessed December 6, 2021, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[47] Opioids are medications that are "effective at reducing pain" but "when taken in excess, can lead to respiratory arrest." Naloxone is a highly effective treatment for reversing an opioid overdose. "Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit," VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, "Automated External Defibrillators (AEDs)," accessed December 16, 2021, https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds. "Pharmacy Benefits Management Services," Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

[48] The El Paso VA Health Care System provides veterans with emergency care, acute inpatient care, and surgical care through their extensive sharing agreement with the William Beaumont Army Medical Center. The OIG conducted the inspection virtually and did not perform a physical inspection at the healthcare system.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of four clinical and administrative areas and provided three recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the System Director and Chief of Staff. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• The Patient Safety Manager conducts a root cause analysis or includes the patient safety event in an aggregate review for all events assigned an actual or potential safety assessment code score of three.
Medical Staff Privileging	• Practitioners with similar training and privileges complete Focused Professional Practice Evaluations of licensed independent practitioners. • The Clinical Executive Board reviews and recommends licensed independent practitioners for reprivileging based on individual practitioners' Ongoing Professional Practice Evaluations and documents its decisions in meeting minutes.
Environment of Care	• None

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 17.[1]

Table B.1. Profile for El Paso VA Health Care System (756)
(October 1, 2018, through September 30, 2021)

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Total medical care budget	$250,090,940	$398,736,066	$443,228,404
Number of:			
• Unique patients	35,759	34,794	35,417
• Outpatient visits	380,203	316,599	357,659
• Unique employees§	870	953	968
Type and number of operating beds	N/A	N/A	N/A
Average daily census	N/A	N/A	N/A

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

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

*****October 1, 2018, through September 30, 2019.*
†*October 1, 2019, through September 30, 2020.*
‡*October 1, 2020, through September 30, 2021.*
§*Unique employees involved in direct medical care (cost center 8200).*

[1] VHA medical facilities are classified according to a complexity model. A designation of "3-Low Complexity" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." "Facility Complexity Level Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). An affiliated healthcare system is associated with a medical residency program. VHA Handbook 1400.03, *Veterans Health Administration Educational Relationships*, February 16, 2016. This healthcare system does not provide inpatient care, so the type and number of operating beds and average daily census are not applicable.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 13, 2022

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Comprehensive Healthcare Inspection of the El Paso VA Health Care System in Texas

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

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

Thank you for the opportunity to respond to the Comprehensive Healthcare Inspection of the El Paso VA Health Care System in Texas. VA remains committed to honoring our Nation's Veterans by ensuring a safe environment to deliver exceptional health care. I agree with the action plans as they have been implemented from the El Paso Leadership team.

I have reviewed and concur with the facility's response and will continue to oversee the progress of the actions.

(Original signed by:)

Wendell Jones, MD, MHA
VISN 17 Network Director

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: September 12, 2022

From: Director, El Paso VA Health Care System (756/00)

Subj: Comprehensive Healthcare Inspection of the El Paso VA Health Care System in Texas

To: Director, VA Heart of Texas Health Care Network (10N17)

1. I have reviewed and concur with the findings and recommendations in the report of the CHIP Review of the El Paso VA Health Care System, El Paso, Texas.

2. Corrective action plans have been implemented with target dates set for completion of the items detailed in the attached report.

(Original signed by:)

Froylan Garza
Executive Director

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