DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 9: VA MidSouth Healthcare Network in Nashville, Tennessee

CHIP REPORT | REPORT #21-03313-96 | APRIL 19, 2023

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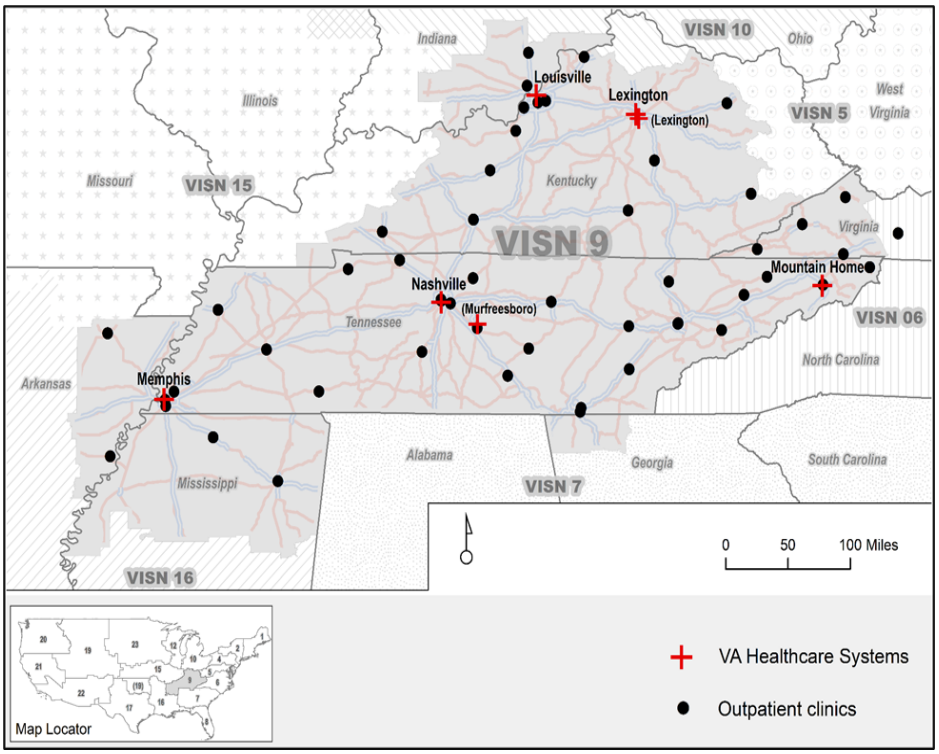

Figure 1. *Veterans Integrated Service Network 9: VA MidSouth Healthcare Network. Source: Veterans Health Administration Site Tracking System.*

Abbreviations

CEOC	Comprehensive Environment of Care
CHIP	Comprehensive Healthcare Inspection Program
CMO	Chief Medical Officer
FY	fiscal year
HCS	healthcare/health care system
OIG	Office of Inspector General
VAMC	VA medical center
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 leadership performance and oversight by the Veterans Integrated Service Network (VISN) 9: VA MidSouth Healthcare Network in Nashville, Tennessee.[1] The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each VISN 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 areas of clinical and administrative operations:

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

The OIG conducted an unannounced virtual inspection of the VA MidSouth Healthcare Network during the week of November 15, 2021. The OIG also inspected the following VISN 9 facilities during the weeks of November 15, November 29, and December 6, 2021:

- Lexington VA Health Care System (Kentucky)[2]
- Memphis VA Medical Center (Tennessee)
- Mountain Home VA Healthcare System (Tennessee)
- Louisville VA Medical Center (Kentucky)
- Tennessee Valley Healthcare System (Nashville)[3]

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. The findings presented in this report are a snapshot of VISN 9 and facility performance within the identified focus areas at the time of the OIG

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

[2] The Lexington VA Health Care System is comprised of the Franklin R. Sousley and Troy Bowling Campuses.

[3] The Tennessee Valley Healthcare System is comprised of the Nashville and Alvin C. York (Murfreesboro) VA Medical Centers.

inspection. The findings may help VISN leaders 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 Network Director in the Environment of Care review area. These results are detailed in the report section and summarized in appendix A on page 19.

Conclusion

The OIG issued three recommendations for improvement to the Network Director. The number of recommendations should not be used as a gauge for the overall quality of care provided within this VISN. The intent is for this VISN leader to use the recommendations as a road map to help improve operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix C, page 21, and the responses within the body of the report for the full text of the director's comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to describe leadership performance and oversight by Veterans Integrated Service Network (VISN) 9: VA MidSouth Healthcare Network.[1] This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so they can make informed decisions to improve care.

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 credentialing and privileging
4. Environment of care
5. Mental health (focusing on suicide prevention)

[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) 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The inspection team conducted an unannounced virtual evaluation during the week of November 15, 2021, and examined select operations. During the virtual visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline. The OIG also inspected the following VISN 9 facilities during the weeks of November 15, November 29, and December 6, 2021:

- Lexington VA Health Care System (HCS) (Kentucky)[5]
- Memphis VA Medical Center (VAMC) (Tennessee)
- Mountain Home VA HCS (Tennessee)
- Louisville VAMC (Kentucky)
- Tennessee Valley HCS (Nashville)[6]

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 VISN leaders complete corrective actions. The VISN Director's responses to the report recommendations appear within the Environment of Care review area. The OIG accepted the action plans that the leader 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 Lexington VA HCS is comprised of the Franklin R. Sousley and Troy Bowling Campuses.

[6] The Tennessee Valley HCS is comprised of the Nashville and Alvin C. York (Murfreesboro) VAMCs.

[7] Inspector General (IG) Act of 1978, as amended, Pub. L. No. 117-286, § 3(b), 136 Stat. 4196, 4206 (2022) (to be codified at 5 U.S.C. §§ 401-24).

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 VISN's risks, the OIG considered several indicators:

1. Executive leadership position stability
2. Employee satisfaction
3. Patient experience
4. Access to care

Executive Leadership Position Stability

The VISN is defined based on Veterans Health Administration's (VHA's) natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. "Under the VISN model, health care is provided through strategic alliances among medical centers, clinics, and other sites, contractual arrangements with private providers, sharing agreements, and other government providers. The VISN is designed to be the basic budgetary and planning unit of the VA health care system."[11]

VISN 9 is an integrated healthcare delivery system that includes whole or parts of seven states (Arkansas, Georgia, Indiana, Kentucky, Mississippi, Tennessee, and Virginia) and borders six other VISNs (5, 6, 7, 10, 15, and 16). VISN 9 is comprised of HCSs, VAMCs, and outpatient clinics. According to data from the VA National Center for Veterans Analysis and Statistics, VISN 9 had a veteran population of 781,125 at the end of fiscal year (FY) 2021 and a projected

[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.

[11] *The Curious Case of the VISN Takeover: Assessing VA's Governance Structure, Hearing Before the Committee on Veterans' Affairs U.S. House of Representatives*, 115th Cong. (May 22, 2018) (statement of Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration).

population of 768,987 by the end of FY 2022. The FY 2021 annual medical care budget of $3,794,966,618 increased approximately 10 percent compared to the previous year's budget of $3,457,715,943.

VISN 9 had an executive leadership team consisting of the interim Network Director, acting Deputy Network Director, Chief Medical Officer (CMO), Quality Management Officer/Chief Nurse Officer, and Chief Human Resources Officer.[12] At the time of the OIG virtual inspection, the VISN was experiencing instability in the top leadership positions, with the network director and deputy network director positions filled by interim or acting staff. The interim Network Director was detailed (temporarily reassigned) in June 2021 to replace the previous interim director, who was detailed to the position after the December 2020 retirement of the permanent director. The Human Resources Officer reported that recruitment efforts for the network director position had been unsuccessful.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] 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 VISN leaders.

The OIG reviewed VA All Employee Survey satisfaction results from FYs 2019 through 2021.[14]

[12] The Network Director is considered "interim" because the director position was vacant at the time the temporary replacement was assigned to the position. The acting Deputy Network Director was assigned to the position after the permanent Deputy Network Director was temporarily assigned to another VA position.

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

[14] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders' All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

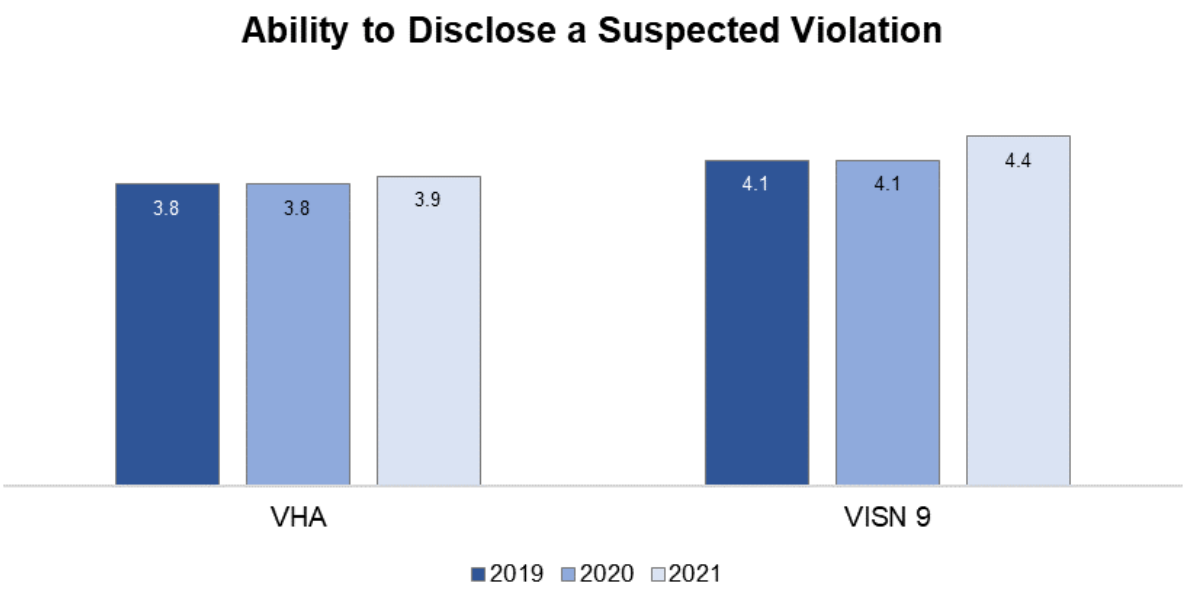

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed October 14, 2021).

Note: *Respondents scored this survey item from 1 (Strongly disagree) through 6 (Not applicable or 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 Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[16] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the VISN from October 1, 2017 (FY 2018), through June 30, 2021. Figures 3–5 provide relevant survey results for VHA and VISN 9.[17]

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

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

[17] Scores are based on responses by patients who received care within the VISN.

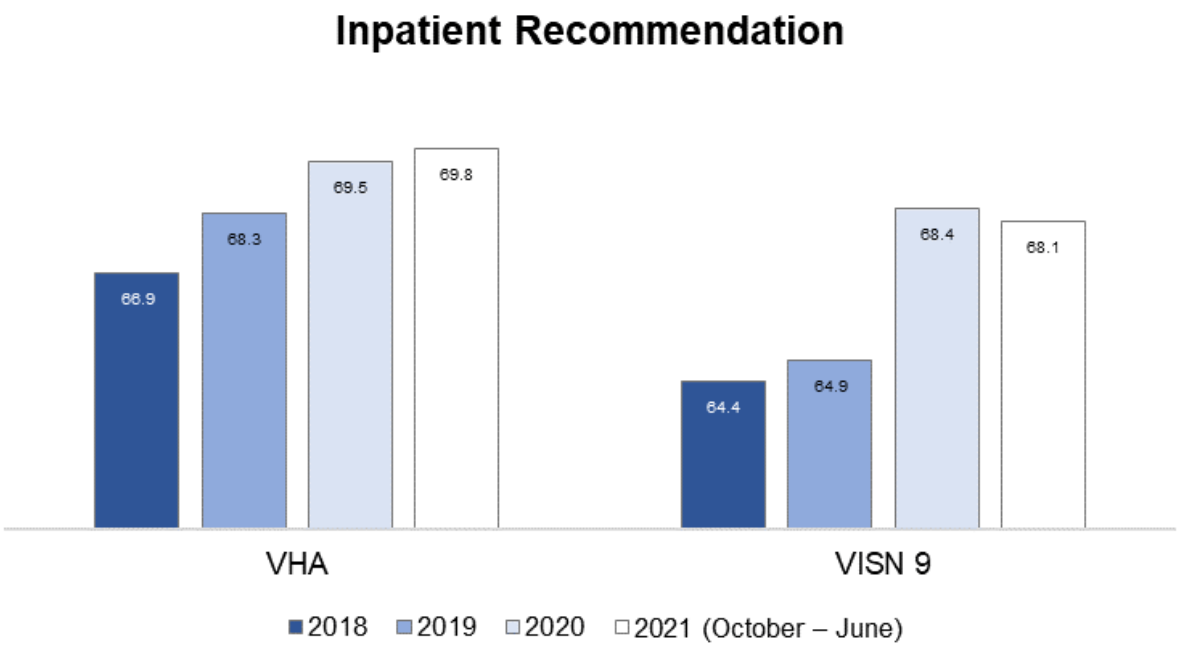

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 20, 2021).

Note: The response average is the percent of "Definitely Yes" responses.

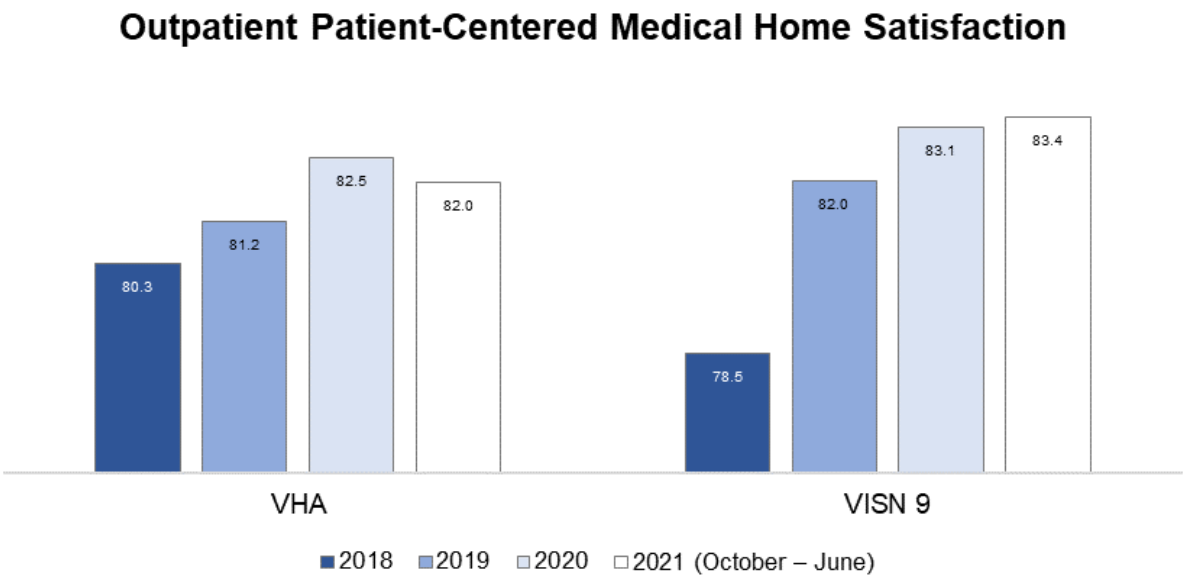

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 20, 2021).

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

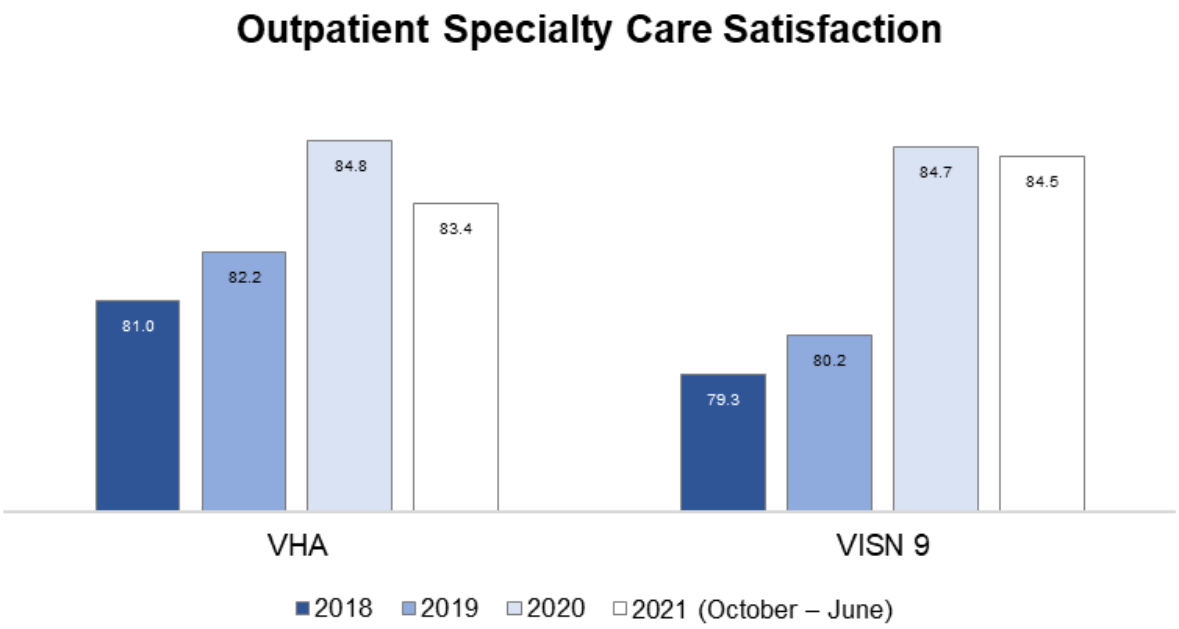

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 20, 2021).

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

Access to Care

A VA priority is ensuring timely access to the best care and benefits for the nation's veterans. VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates. VHA's goal is to provide patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[18]

To examine access to primary and mental health care within VISN 9, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 1 and 2 provide wait time statistics for

[18] The "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity." VHA Directive 1230(5), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended September 24, 2021. (This directive was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.)

completed primary care and mental health appointments from July 1 through September 30, 2021.[19]

Table 1. Primary Care Appointment Wait Times (July 1 through September 30, 2021)

Facility	New Patient Appointments	Average New Patient Wait Times from Create Date (Days)
VISN 9	5,024	18.2
Lexington VA HCS (Kentucky)	525	16.9
Memphis VAMC (Tennessee)	837	17.4
Mountain Home VA HCS (Tennessee)	1,489	12.5
Louisville VAMC (Kentucky)	940	13.4
Tennessee Valley HCS (Nashville)	1,233	26.0

Source: VHA Support Service Center (accessed October 14, 2021).

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

Table 2. Mental Health Appointment Wait Times (July 1 through September 30, 2021)

Facility	New Patient Appointments	Average New Patient Wait Times from Create Date (Days)
VISN 9	1,367	14.6
Lexington VA HCS (Kentucky)	82	9.6
Memphis VAMC (Tennessee)	235	9.1
Mountain Home VA HCS (Tennessee)	155	17.3
Louisville VAMC (Kentucky)	146	18.5
Tennessee Valley HCS (Nashville)	749	14.8

Source: VHA Support Service Center (accessed October 14, 2021).

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

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[19] Primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine. Mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual.

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."[20] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[21] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as those from The Joint Commission), and federal regulations.[22]

To determine whether VISN staff implemented OIG-identified key processes for quality and safety and incorporated them into their activities, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

[21] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (This directive was rescinded and replaced with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

[22] VHA Directive 1100.16.

Medical Staff Credentialing and Privileging

The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with VHA policy," which includes the VISN CMO's oversight of credentialing and privileging processes at VISN facilities.[23] "Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system. Credentials are documented evidence of licensure, education, training, experience, or other qualifications."[24]

When certain actions are taken against a physician's licenses, the senior strategic business partner (previously known as the human resources officer) will make a recommendation to the VISN chief human resources officer, who will then determine whether the physician meets licensure requirements for VA employment.[25] Further, the VISN CMO is required to document a review for any licensed independent practitioner with a history of a "license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application."[26] The VISN CMO must then "make a recommendation to the VHA medical facility that initiated the review process on the appropriateness of continuing with the LIP's [licensed independent practitioner's] credentialing application or appointment at the facility."[27]

The OIG inspection team reviewed information for 134 physicians hired at facilities within the VISN from October 14, 2020, and still employed as of October 14, 2021.[28] When reports from the National Practitioner Data Bank or Federation of State Medical Boards appeared to confirm

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

[24] VHA Directive 1100.20.

[25] VHA Credentialing Directive 1100.20: Standard Operating Procedure – C25 version 3, *Mandatory Reviews of Adverse Licensure, Certification, or Registration Actions*, October 2, 2020. Providers are ineligible for VA appointment if they do not have a full unrestricted license, had a license revoked (without it being fully restored), or surrendered a license (in lieu of revocation). 38 U.S.C. § 7402.

[26] VHA Handbook 1100.19.

[27] A licensed independent practitioner "is any individual permitted by law...and the facility to provide patient care services independently, i.e., without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." VHA Handbook 1100.19. VHA Credentialing Directive 1100.20: Standard Operating Procedure – C40 version 2, *Conducting and Documenting a Chief Medical Officer Credentials Review*, November 9, 2020.

[28] The VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, [and] focused on the approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards." The OIG reviewed VISN facility physicians hired from October 14, 2020, to continue efforts to identify staff not meeting VHA employment requirements since "VHA officials told us [GAO] these types of reviews are not routinely conducted…[and] that the initial review was labor intensive." GAO, *Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6, February 2019.

that a physician has a potentially disqualifying licensure action requiring further review, inspectors examined evidence of the

- Senior Strategic Business Partner's and VISN Chief Human Resources Officer's review to determine whether the physician satisfies VA licensure requirements, and
- VISN CMO's review and recommendation for any licensed independent practitioner with a specific licensure or malpractice history.[29]

Further, VHA has defined processes for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[30] Practitioners who had their privileges reduced and disagree with the decision have the right to request a hearing. If the hearing results in the reduction of privileges, practitioners may appeal to the VISN director, who "must provide a written decision, based on the record, within 20 business days after receipt of the practitioner's appeal."[31]

Medical Staff Credentialing and Privileging Findings and Recommendations

The OIG made no recommendations.

[29] "The National Practitioner Data Bank (NPDB) is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers." "Health Workforce Data, Tools, and Dashboards," Health Resources & Services Administration, accessed August 24, 2022, https://data.hrsa.gov/topics/health-workforce/npdb. "The Federation of State Medical Boards represents the state medical and osteopathic regulatory boards – commonly referred to as state medical boards…[to] fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals." "About FSMB," Federation of State Medical Boards, accessed August 24, 2022, https://www.fsmb.org/about-fsmb/.

[30] VHA Handbook 1100.19.

[31] VHA Handbook 1100.19.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that healthcare facilities provide a safe, clean, and functional environment of care for veterans, their families, visitors, and employees in accordance with applicable environment of care accreditation standards and federal regulatory and applicable VA and VHA requirements. 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.[32]

To support these efforts, VHA requires VISNs to have a Comprehensive Environment of Care "(CEOC) oversight program with a charter."[33] VHA "provides policy, mandatory standards, and operational requirements for implementing an effective VHA Supply Chain Management (SCM) program at medical facilities," which includes responsibility for VISN-level oversight.[34] VHA also mandates that VISN leaders ensure network facilities with acute inpatient mental health units submit their Mental Health Environment of Care Checklist review via the Patient Safety Assessment Tool every six months.[35]

The OIG inspection team reviewed relevant documents and interviewed VISN managers.

Environment of Care Findings and Recommendations

VHA requires the VISN director to submit "a compliance report, incorporating CEOC data from each VA medical facility within their VISN, to the CEOC Steering Committee on an annual basis."[36] Because the Emergency/Safety and Capital Asset Managers stated the FY 2021 compliance report was not due until November 30, 2021, the OIG requested, but did not receive, evidence of an FY 2020 compliance report submitted to the Environment of Care Committee.[37] Failure to submit the report may prevent leaders from identifying facilities' environmental issues that require VISN assistance. The Emergency/Safety and Capital Asset Managers stated that due to the COVID-19 pandemic, facility staff did not complete some of their CEOC inspections, so the data were not useful. The Capital Asset Manager also reported deviating from required

[32] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021; VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[33] VHA Directive 1608.

[34] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[35] The Mental Health Environment of Care Checklist "was designed to help facilities identify and address environmental risks for suicide and suicide attempts." The Patient Safety Assessment Tool is a web-based system used for staff to respond to deficiencies found on the Environment of Care Checklist and track the implementation of corrective action plans. VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients,* May 12, 2017.

[36] VHA Directive 1608.

[37] This VISN's CEOC Steering Committee equivalent is the Environment of Care Committee.

inspections during the pandemic but not documenting justification as required by the March 2020 Deputy Under Secretary for Health for Operations and Management memorandum.[38]

Recommendation 1

1. The Network Director evaluates and determines additional reasons for noncompliance and submits a Comprehensive Environment of Care compliance report to the Environment of Care Committee annually.

Veterans Integrated Service Network concurred.

Target date for completion: December 30, 2023

Veterans Integrated Service Network response: The VISN Safety Manager with support from the VISN Comprehensive Environment of Care [CEOC] Committee will conduct an annual assessment of committee activities, effectiveness, performance, and improvement goals by November 30th. This report will then be submitted annually to the December's Healthcare Operations Committee (HOC) chaired by the Deputy Network Director, which via the governance structure will flow up to the Executive Leadership Committee chaired by the Network Director. The annual assessment of committee activities will be added to the VISN CEOC Committee reporting matrix.

VHA requires the VISN director to ensure staff in the CEOC oversight program perform a quarterly review of CEOC Compliance and Assessment Tool data.[39] The OIG did not find evidence the Environment of Care Committee (responsible for CEOC oversight) reviewed quarterly data for FYs 2020 or 2021. Failure to review CEOC data could result in missed opportunities for leaders to address issues affecting patient safety. The Emergency/Safety and Capital Asset Managers reported they received VHA guidance that granted facilities flexibility in scheduling or postponing inspections during the COVID-19 pandemic, which resulted in limited data to review. The managers also attributed the noncompliance to competing pandemic-related responsibilities.

[38] Deputy Under Secretary for Health for Operations and Management memo, "COVID-19 Guidance on Inspections, Fire Drills, and Routine Equipment Maintenance," March 20, 2020.

[39] VHA Directive 1608.

Recommendation 2

2. The Network Director evaluates and determines additional reasons for noncompliance and makes certain the Environment of Care Committee reviews Comprehensive Environment of Care Compliance and Assessment Tool data at least quarterly.

Veterans Integrated Service Network concurred.

Target date for completion: October 30, 2023

Veterans Integrated Service Network response: The VISN Safety Manager will provide quarterly reports of the data from the CEOC Compliance and Assessment Tool to the VISN CEOC committee for analysis and opportunities for improvement. The report will track and review: Closed deficiencies identified during CEOC rounds or have a documented plan for action (PFA) within 14 business days; An executive team member defined as a Quadrad or Pentad official will attend CEOC rounds conducted at VA Medical Centers and leased spaces at least 90% of the time; Each core CEOC team member role will attend and conduct CEOC rounds 90% of the time or greater; and Completion of CEOC checklists within 5 business days of scheduled CEOC rounds. The documented reports will be presented to the HOC on a quarterly basis. The CEOC Compliance and Assessment Tool will be added to the HOC reporting matrix.

VHA requires VISN directors, through their emergency management committees, to conduct an annual "review of the collective VISN-wide strengths, weaknesses, priorities and requirements for improvement that is documented in writing."[40] The OIG found the Emergency Management Committee conducted its last annual review in 2019. Failure to conduct the annual review could prevent emergency management readiness. The Emergency/Safety Manager acknowledged that the lack of a 2020 review was an oversight.

Recommendation 3

3. The Network Director evaluates and determines any additional reasons for noncompliance and ensures the Emergency Management Committee conducts an annual review of the Veterans Integrated Service Network-wide strengths, weaknesses, priorities, and requirements for improvement, and documents it in writing.

[40] VHA Directive 0320.01.

Veterans Integrated Service Network concurred.

Target date for completion: November 30, 2023

Veterans Integrated Service Network response: The VISN Emergency Manager will provide the VISN Deputy Network Director an annual review of the VISN 9 Network wide strengths weaknesses, priorities, and requirements for improvement by COB [close of business] October 15th each year. The Deputy Network Director will have till [until] October 31st to review and provide comments. Once the report is reviewed by the Deputy Network Director, the VISN Emergency Manager will update the report as needed and submit the review to the Healthcare Operations Committee by November 30th of each year. The annual review of the VISN 9 Network Emergency Management Program will be added to the HOC reporting matrix.

Mental Health: Suicide Prevention

Suicide prevention remains a top priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides among U.S. adults."[41] Additionally, "among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019."[42]

VHA requires VISN leaders to appoint mental health staff to serve on the primary VISN governing body, participate on each state's suicide prevention council or workgroup, coordinate activities with state and local mental health systems and community providers, and serve as the VISN representative for the Suicide Prevention Program.[43]

The OIG reviewed relevant documents and interviewed managers to determine whether VISN staff complied with various suicide prevention requirements.

Mental Health Findings and Recommendations

The OIG made no recommendations.

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

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

[43] VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015; VHA Directive 1160.07, *Suicide Prevention Program,* May 24, 2021.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care within this VISN, the OIG conducted a detailed review of five clinical and administrative areas and provided three recommendations on issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this VISN. 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 that are attributable to the Network Director. The intent is for this VISN leader to use the recommendations to help improve operations and clinical care. The recommendations address findings 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	• None
Medical Staff Credentialing and Privileging	• None
Environment of Care	• The Network Director submits a Comprehensive Environment of Care compliance report to the Environment of Care Committee annually. • The Environment of Care Committee reviews Comprehensive Environment of Care Compliance and Assessment Tool data at least quarterly. • The Emergency Management Committee conducts an annual review of the Veterans Integrated Service Network-wide strengths, weaknesses, priorities, and requirements for improvement, and documents it in writing.
Mental Health: Suicide Prevention	• None

Appendix B: VISN 9 Profile

The table below provides general background information for VISN 9.

Table B.1. Profile for VISN 9
(October 1, 2018, through September 30, 2021)

Profile Element	VISN Data FY 2019*	VISN Data FY 2020†	VISN Data FY 2021‡
Total medical care budget	$2,750,832,354	$3,457,715,943	$3,794,966,618
Number of:			
• Unique patients	293,490	290,012	299,196
• Outpatient visits	4,046,766	3,813,801	4,216,794
Unique employees§	12,103	12,201	12,528
Type and number of operating beds:			
• Community living center	348	348	282
• Domiciliary	256	242	180
• Hospital	640	637	637
Average daily census:			
• Community living center	326	254	195
• Domiciliary	204	123	88
• Hospital	436	389	412

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 20, 2023

From: Director, VA MidSouth Healthcare Network (10N9)

Subj: Comprehensive Healthcare Inspection of Veterans Integrated Service Network 9: VA MidSouth Healthcare Network

To: Director, Office of Healthcare Inspections (54CH04)

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

1. I have reviewed the findings and recommendations in the OIG report entitled, Draft Report: Comprehensive Healthcare Inspection of Veterans Integrated Service Network 9: VA MidSouth Healthcare Network. I concur with the action plans submitted.

2. We thank the OIG for the opportunity to review and respond to the Draft Report: Comprehensive Healthcare Inspection of Veterans Integrated Service Network 9: VA MidSouth Healthcare Network.

(Original signed by:)

Gregory Goins, FACHE
Network Director, VISN 9

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Randall Snow, JD, Team Leader Tishanna McCutchen, DNP, MSPH
Other Contributors	Shirley Carlile, BA Kaitlyn Delgadillo, BSPH Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Yurong Tan, PhD Elizabeth K. Whidden, MS, APRN

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