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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Tennessee Valley Healthcare System in Nashville

CHIP REPORT | REPORT #21-03312-114 | MAY 16, 2023

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Figure 1. *Nashville VA Medical Center of the Tennessee Valley Healthcare System.*

Source: *https://www.va.gov/tennessee-valley-health-care*.

Abbreviations

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
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 Tennessee Valley Healthcare System, which includes the Nashville VA Medical Center, the Alvin C. York VA Medical Center (Murfreesboro), and multiple outpatient clinics in Kentucky and Tennessee. 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 emergency department and urgent care center suicide prevention initiatives)

The OIG conducted an unannounced inspection of the Tennessee Valley Healthcare System during the week of December 6, 2021. 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 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 eight recommendations to the Executive Director, Chief of Staff, and Deputy Health System Director in the following areas of review: Leadership and Organizational Risks; Quality, Safety, and Value; Medical Staff Privileging; and Environment of Care. These results are detailed throughout the report and summarized in appendix A on page 27.

Conclusion

The OIG issued eight recommendations for improvement to the Executive Director, Chief of Staff, and Deputy Health System Director. The number of recommendations should not be used as a gauge for the overall quality of care provided at this 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 Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 30–31, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 3 and 8 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Tennessee Valley 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 emergency department and urgent care center suicide prevention initiatives)

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

Methodology

The Tennessee Valley Healthcare System includes the Nashville VA Medical Center, the Alvin C. York VA Medical Center (Murfreesboro), and associated outpatient clinics in Kentucky and Tennessee. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from October 2, 2017, through December 10, 2021, the last day of the unannounced multiday evaluation.[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.

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 Executive Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the Tennessee Valley Healthcare System occurred in October 2017. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in September 2019.

[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 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 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

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 Health System Director, Deputy Health System Director, Chief of Staff, Associate Director for Patient Care Services, Associate Director of the Nashville VA Medical Center, and Associate Director of the Alvin C. York VA Medical Center (Murfreesboro).[10] The Chief of Staff and Associate Director for Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive leaders had worked together for less than one month, although the Chief of Staff had served in the role since 2017 and Associate Director (Nashville) since 2020. To help assess the executive leaders' engagement, the OIG interviewed

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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, *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.

[10] Leaders used these titles at the time of the inspection; the Health System Director's new title is Executive Director.

the acting Health System Director, Chief of Staff, acting Associate Director for Patient Care Services, and Associate Director (Nashville) regarding their knowledge, involvement, and support of actions to improve or sustain performance.[11]

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $1,252,876,627 had increased by approximately 9 percent compared to the previous year's budget of $1,149,930,293.[12] When asked about the effect of this change on the healthcare system's operations, the acting Health System Director and Associate Director (Nashville) stated that leaders reevaluated organizational charts and funded needed positions. Further, the Associate Director (Nashville) shared that additional funds helped leaders address challenges in replacing aging equipment and furnishings such as waiting room furniture.

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.[14] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[15]

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[11] The acting Health System Director, who was permanently assigned as the VISN 9 Chief Medical Officer, was detailed (temporarily assigned) to the position in November 2021.

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

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

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

[15] 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 variation in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

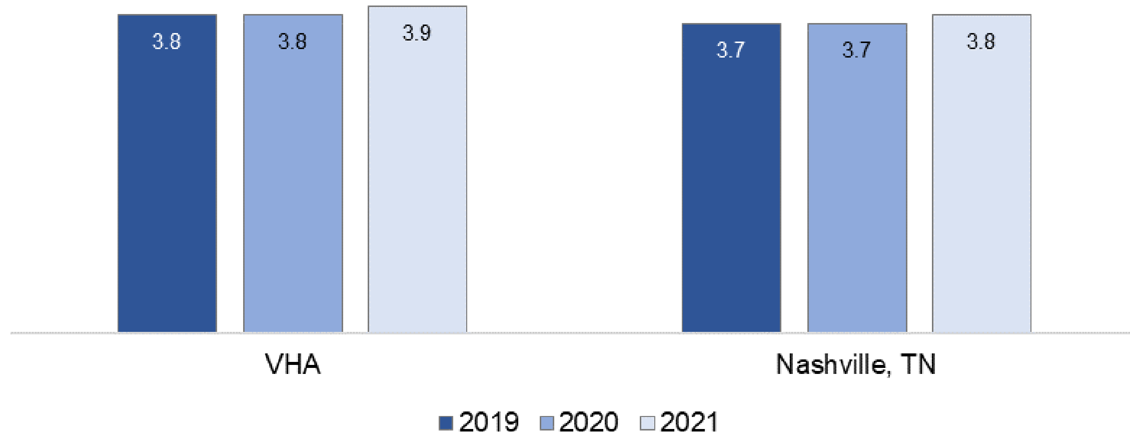

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed November 2, 2021).

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

Patient Experience

Veterans Health Administration (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.[16]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[17] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system. Figures 3–5 provide survey results for VHA and the healthcare system over time.[18]

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

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

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

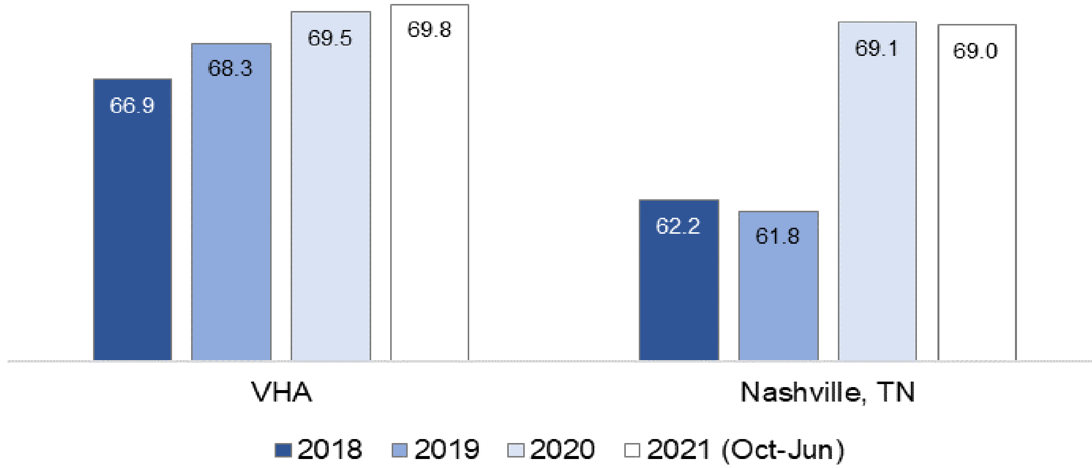

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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

Note: The score is the percent of "Definitely yes" responses.

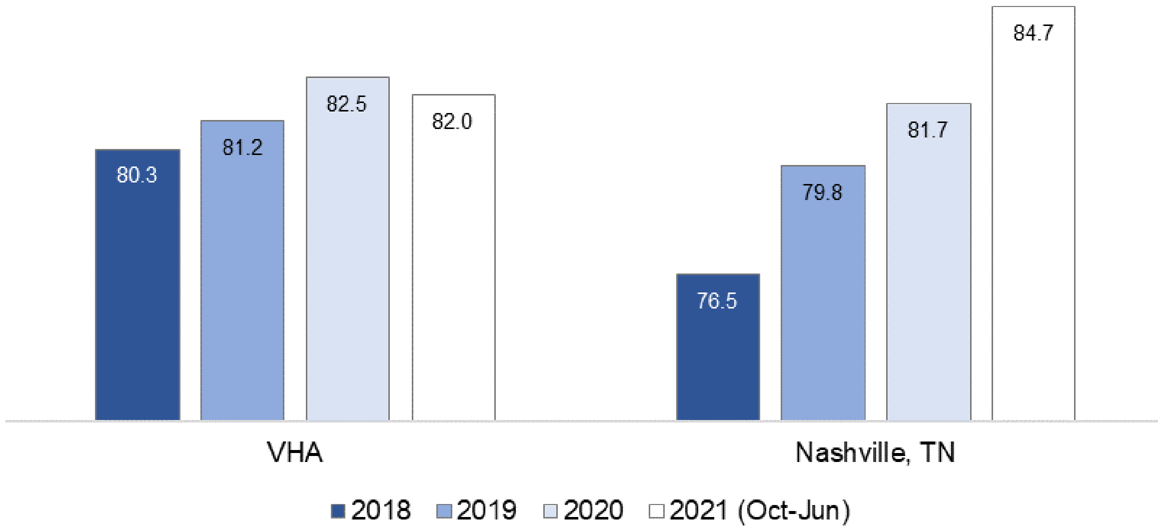

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

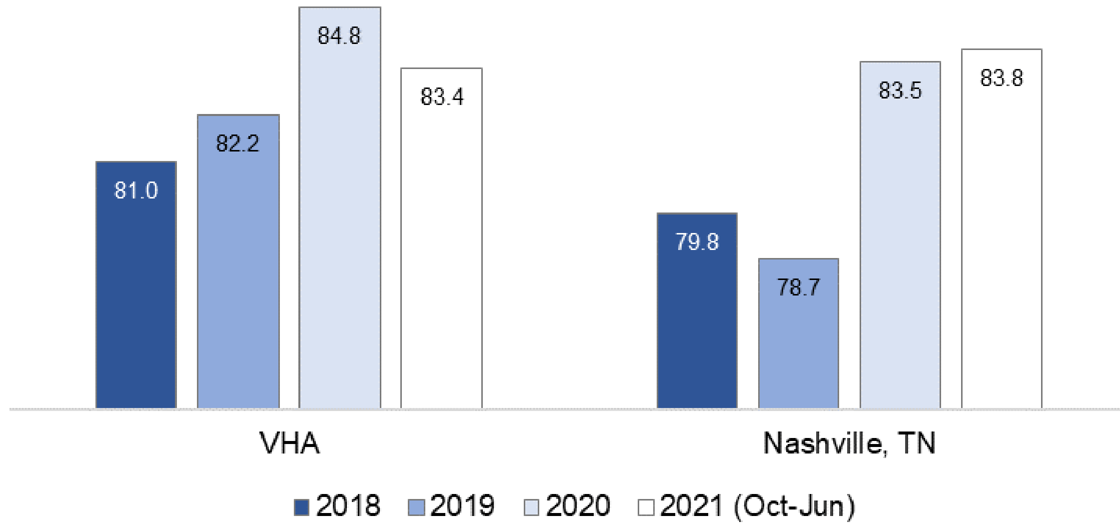

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed September 20, 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 patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[19] A sentinel event is an incident or condition that "results in death, permanent harm, or severe temporary harm and [when] intervention [is] required to sustain life."[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

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[19] 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/.

[20] 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.

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.

Table 1 lists the OIG-requested adverse patient safety events that occurred since the prior OIG CHIP site visit in October 2017.

Table 1. Adverse Patient Safety Events

Factor	Number of Occurrences
Sentinel Events	31
Institutional Disclosures	12
Large-Scale Disclosures	0

Source: Tennessee Valley Healthcare System's Patient Safety Manager and Risk Manager.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[23] 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.[24]

The acting Health System Director spoke about serious adverse event reporting processes, which included reviewing reports from the Joint Patient Safety Reporting System in morning huddles with the executive leadership team.[25] In addition, the acting Health System Director reported working with the Chief of Staff, service chiefs, and other executive leaders to decide whether an institutional disclosure was warranted. The OIG identified concerns with the leaders' completion of institutional disclosures. Specifically, the OIG determined that leaders did not perform institutional disclosures for all applicable sentinel events.

The OIG also identified trends within the sentinel events under review. Fourteen sentinel events involved a patient fall and three involved delays in staff providing emergent care. The Accreditation Readiness Coordinator stated that these trends were recognized. In the case of falls, the leaders implemented a training program for staff who supervise patients at risk of fall.

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[22] VHA Directive 1004.08.

[23] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

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

[25] The Joint Patient Safety Reporting (JPSR) System is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *2020 | JPSR Business Rules and Guidebook*, July 2020.

According to the Patient Safety Manager, leaders recommended a safety stand down and mock drills to improve the trend in emergent care delays.

Leadership and Organizational Risks Findings and Recommendations

VHA recognizes that the disclosure of harmful events is "consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence" and requires leaders to inform or disclose to a patient or patient's personal representative when a sentinel event occurs.[26] The OIG determined that leaders did not perform institutional disclosures for all sentinel events that may have contributed to the patient's death. Failure to conduct institutional disclosures following a sentinel event may reduce patients' trust in the organization. The Accreditation Readiness Coordinator acknowledged that leaders did not consistently conduct institutional disclosures but recently implemented changes in this process.

Recommendation 1

1. The Executive Director determines the reasons for noncompliance and ensures leaders conduct institutional disclosures for all applicable sentinel events.

[26] VHA Directive 1004.08.

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: Executive Director will ensure appropriately designated and trained leadership will conduct institutional disclosures of sentinel events.

Formal training on institutional disclosures will be conducted by the Office of General Counsel (OGC) and the Ethics Office in collaboration with the Tennessee Valley Healthcare System (TVHS) Risk Management staff on May 3rd, 2023. Attendance will be recorded.

[The] Chief of Quality, Safety, and Value (QSV) and Risk Manager will review all events meeting criteria for institutional disclosure with [the] Chief of Staff monthly, at minimum. The criterion for an institutional disclosure is an adverse event that has resulted in or is reasonably expected to result in serious injury or death. An institutional disclosure must be performed regardless of when the event is discovered. The source of information will be derived from Executive Concerns, Joint Patient Safety Reports, Peer Reviews, and Occurrence Screens which indicate serious injury or death.

At least 90% of Institutional Disclosures will be completed for two consecutive quarters. This data will be reported to the Quality, Safety, and Value Council quarterly on an ongoing periodicity to ensure compliance.

Risk Management will maintain documentation on the facility developed comprehensive checklist tool of all events meeting criteria for Institutional Disclosure to include the completion date of the Institutional Disclosure.

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."[27] To meet this goal, VHA requires staff at its facilities to 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 (such as those from The Joint Commission).[29]

To determine whether VHA facility staff 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 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.[30] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[31] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[32]

Finally, the OIG assessed the healthcare system's culture of safety.[33] 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 reviewers interviewed managers and key employees and evaluated meeting minutes, patient safety reports, and other relevant information.

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

[28] 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.)

[29] VHA Directive 1100.16.

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

[31] VHA Directive 1190.

[32] VHA Directive 1190.

[33] 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 states that medical facility directors are responsible for ensuring final peer reviews are completed within 120 calendar days from the determination that a peer review is needed or approving a written extension request.[34] For the 11 Level 3 peer reviews completed from December 2020 through November 2021, the OIG found that staff did not complete 2 within the expected time frame.[35] This could prevent timely improvements in patient care throughout the healthcare system. The Risk Management Specialist stated that staff calculated the 120-day range using the date the case was sent to the initial peer reviewer instead of the date the Director signed the designation memo, which resulted in incorrect dates for completion.

Recommendation 2

2. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures staff complete final peer reviews within 120 calendar days or approves a written extension request.

Healthcare system concurred.

Target date for completion: September 1, 2023

Healthcare system response: Monthly audits of Peer Review Designation memos will be conducted to ensure Peer Review Designation memo dates match information submitted on the VHA Support Service Center (VSSC) Peer Review spreadsheet and cases are completed within 120 days of designation memo date or have an extension granted by the Executive Director. Monthly audits will be conducted until 90% compliance is achieved for two consecutive quarters. Compliance will be reported to the Medical Executive Committee quarterly.

VHA requires that “all events receiving an actual or potential SAC [safety assessment code] score of three receive either an individual RCA [root cause analysis] or must be included in an Aggregated Review.”[36] The OIG found that from December 2020 through November 2021, staff did not conduct an individual root cause analysis for 12 of 30 events with a potential safety assessment code score of three or include the events in an aggregated review.[37] The lack of root cause analyses diminishes the ability for staff to identify and mitigate system vulnerabilities to

[34] VHA Directive 1190.

[35] A peer review is assigned a Level 3 when “most experienced and competent clinicians would have managed the case differently.” VHA Directive 1190.

[36] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This handbook was rescinded and replaced with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

[37] 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.

reduce patient harm. Three of the events occurred in a community care environment. The Patient Safety Manager stated that of the remaining 9 events, 4 were to be included in medication or wildcard aggregate reviews that were due in calendar year 2022. The Patient Safety Manager also reported that the other 5 events were similar to other patient safety events that resulted in root cause analyses with ongoing process improvement projects. The Patient Safety Manager expressed believing that no additional improvement opportunities would be gained from an individual root cause analysis and leaders decided to focus aggregate reviews on lesser addressed patient safety issues.

Recommendation 3

3. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures that for all patient safety events assigned an actual or potential safety assessment code score of three, the Patient Safety Manager conducts an individual root cause analysis or includes the events in an aggregate review.[38]

Healthcare system concurred.

Target date for completion: Complete

Healthcare system response: [The] Executive Director ensures all patient safety events assigned an actual or potential Safety Assessment Code (SAC) of 3 have a Root Cause Analysis (RCA) conducted or are included in an aggregate RCA.

The Patient Safety Manager will ensure 90% of actual or potential SAC scores of 3 will have an individual RCA conducted or be included in an aggregate RCA review for two consecutive quarters.

[38] The OIG reviewed evidence sufficient to demonstrate that healthcare system staff completed improvement actions, and therefore, closed the recommendation before publication of the report.

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."[39] 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."[40]

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.[41] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[42]

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."[43] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[44] 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.[45]

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.[46] 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

[39] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This handbook was rescinded and replaced by VHA Directive 1100.21, *Privileging*, March 2, 2023. The credentialing portion of this handbook was previously replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[40] VHA Handbook 1100.19.

[41] VHA Handbook 1100.19.

[42] VHA Handbook 1100.19.

[43] VHA Handbook 1100.19.

[44] VHA Handbook 1100.19.

[45] VHA Handbook 1100.19.

[46] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[47]

The OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

- One solo or few practitioner who underwent clinical privileging in the previous 12 months[48]
- Ten 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 FPPE criteria "to be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process and approved by the Director."[49] The OIG found that all 10 folders reviewed lacked evidence that LIPs were aware of the evaluation criteria before service chiefs initiated the FPPE process. When LIPs are not informed of the evaluation criteria, they may misunderstand FPPE expectations. The Supervisory Health Systems Specialist to the Chief of Staff reported that due to a lack of oversight, service chiefs used a standardized form that did not include a place for the LIP to sign in advance.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs use Focused Professional Practice Evaluation criteria that are defined in advance and accepted by the practitioners.

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[47] 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.

[48] 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 few practitioners as being two providers in the facility who are privileged in a particular specialty.

[49] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response: [The] Chief of Staff will ensure clinical indicators and specialty-specific criteria are documented on [the] Focused Professional Practice Evaluation (FPPE) and provided to Licensed Practitioners (LP) prior to the LP providing direct patient care.

Service Chiefs will provide to [the] Credentialing and Privileging Manager the FPPE form signed by the LP, mentor, and Service Chief within five business day[s] of signatures obtained.

[The] Credentialing and Privileging Manager will provide weekly updates to the Credentialing Committee on FPPE form signature compliance and will provide [a] monthly update on FPPE form signature compliance to the Continuous Readiness Committee. Reporting will continue until 90% compliance has been sustained for two consecutive quarters.

VHA also requires an executive committee of the medical staff to review and evaluate LIPs' privileging requests. Committee minutes must indicate the materials reviewed and the rationale for the conclusion.[50] The OIG found that the system's executive committee (known as the Medical Executive Committee) did not review FPPEs and OPPEs for LIPs' privileging requests. Failure of the Medical Executive Committee to review LIPs' evaluations may result in inadequate evidence to support clinical privileges, which could negatively affect quality of care and patient safety. The Chief of Staff and Credentialing and Privileging Manager stated that FPPE and OPPE results were discussed at the Medical Executive Committee meetings but not adequately recorded in the minutes.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Medical Executive Committee reviews professional practice evaluations for licensed independent practitioners' privileging requests and documents the review in meeting minutes.

[50] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response: [The] Chief of Staff will ensure completed FPPE results with recommendations are reported to and reviewed by the Credentialing Committee and Medical Executive Committee prior to [the] Licensed Practitioner (LP) advancing to an Ongoing Professional Practice Evaluation (OPPE).

[The] Chief of Staff will ensure Medical Executive Committee minutes document the FPPE and OPPE discussion from the Credentialing Committee monthly and report compliance to the Continuous Readiness Committee monthly until 90% compliance is sustained for two consecutive quarters.

[The] Credentialing and Privileging Manager will complete monthly audit[s] of FPPEs and OPPEs for completeness and accuracy and report compliance to the Credentialing Committee and Continuous Readiness Committee monthly until 90% compliance is sustained for two consecutive quarters.

VHA requires that each service chief "establish additional criteria for granting of clinical privileges within the service consistent with the needs of the service and the facility as well as within the available resources to provide these services."[51] The OIG noted that service chiefs did not consistently establish service-specific criteria in the granting of continued privileges. This could have resulted in service chiefs lacking adequate data to support continued privileges, and practitioners delivering care without a thorough review of their practice. The Supervisory Health Systems Specialist to the Chief of Staff stated that due to a lack of oversight, some service chiefs used a standardized OPPE form.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs establish service-specific criteria for reprivileging decisions.

[51] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: September 1, 2023

Healthcare system response: [The] Chief of Staff will review OPPEs for all services during the Medical Executive Committee meeting to ensure Service Chiefs include service-specific criteria on OPPEs, which will be used to evaluate and determine Licensed Practitioner renewal of privileges.

[The] Credentialing and Privileging Manager will complete an audit of all service OPPEs for service-specific criteria and report compliance to [the] Credentialing Committee and monitor until compliance with service-specific criteria is on at least 90% of all services' OPPEs for two consecutive quarters.

VHA requires that service chiefs' recommendations to continue current privileges be based, in part, on OPPE activities such as direct observation, clinical pertinence reviews, and clinical discussions. VHA also requires that a practitioner with similar training and privileges evaluate the competency of an LIP during the OPPE process.[52] The OIG found that service chiefs did not consistently recommend the continuation of privileges based, in part, on OPPEs completed by similarly trained and privileged practitioners. This could have resulted in LIPs delivering care without thorough evaluations of their practice. The Chief of Staff and Credentialing and Privileging Manager both stated that service chiefs recommended reprivileging when they discussed OPPE results during Medical Executive Committee meetings, but the discussions were not recorded in the minutes. Further, the Supervisory Health Systems Specialist to the Chief of Staff expressed believing that similarly trained and privileged practitioners evaluated the LIPs but did not always sign the OPPE forms.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs recommend reprivileging based, in part, on Ongoing Professional Practice Evaluations completed by practitioners with similar training and privileges.

[52] 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."

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response: [The] Chief of Staff will ensure all OPPEs are completed by a Licensed Practitioner with similar training and privileges.

OPPEs will be reviewed by the Credentialing Committee within seven business days and discussion will be documented in the committee minutes and specifically address credentials of the peer completing the OPPE.

[The] Credentialing and Privileging Manager will audit OPPEs for compliance monthly and report compliance monthly to the Credentialing Committee and Continuous Readiness Committee until 90% compliance is sustained for two consecutive quarters.

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.[53] The physical environment of a healthcare organization must not only be functional but should also promote healing.

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 assessed compliance in 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.[54]

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.[55] 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 during emergencies and contribute to a safe healthcare environment.[56]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 16 patient care areas:

- Nashville VA Medical Center
    - Emergency Department

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

[54] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

[55] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[56] 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.

    - Intensive care units (medical and surgical)
    - Medical/surgical inpatient unit (2N)
    - Mental health inpatient unit (4N)
    - Outpatient Specialty Care (dermatology)
    - Post-anesthesia care unit
- Alvin C. York VA Medical Center (Murfreesboro)
    - Community living centers (East, West, and Southwest)
    - Medical/surgical inpatient unit (Building 1)
    - Mental health inpatient units (7A and 7B)
    - Primary care clinics (PODs A and B)
    - Urgent care center

Environment of Care Findings and Recommendations

VHA states the facility chief of staff and nurse executive (Associate Director for Patient Care Services) are responsible for ensuring staff "understand the hazards" of environmental risks for suicide and suicide attempts in acute inpatient mental health units and "develop appropriate abatement plans."[57] Further, The Joint Commission requires hospital staff to identify environmental elements that could be used by patients to attempt suicide and take action to minimize the risk.[58] The OIG found that patient bathrooms located in two of three mental health units inspected had mirrors that provided anchor points which could be used for hanging and result in patients' self-inflicted harm.[59] The Nurse Manager stated that the mirrors were approved mental-health-unit equipment and believed they met the requirement.

[57] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

[58] The Joint Commission, "National patient safety goal for suicide prevention," R3 Report: Requirement, Rationale, Reference (2019), https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/suicide-prevention/r3_18_suicide_prevention_hap_bhc_5_6_19_rev5.pdf?db=web&hash=887186D9530F7BB8E30C28FE352B5B8C&hash=887186D9530F7BB8E30C28FE352B5B8C.

[59] The OIG identified the deficiencies in mental health units 7A and 7B at the Alvin C. York VA Medical Center.

Recommendation 8

8. The Deputy Health System Director evaluates and determines any additional reasons for noncompliance and ensures staff identify and minimize physical environmental risks to reduce suicide or suicide attempts in acute inpatient mental health units.[60]

Healthcare system concurred.

Target date for completion: Complete

Healthcare system response: December 10, 2021, Chief, Engineering and Chief Nurse, Mental Health assessed the mirrors in all rooms on the inpatient units 7A and 7B and determined all 75 mirrors should be replaced to be current with Behavioral Health design guides.

Chief Nurse, Mental Health developed and implemented a risk mitigation plan to ensure Veteran safety pending mirror replacement.

December 21, 2021, purchased 75 ligature resistant framed mirrors from Behavioral Safety Products, LLC.

January 13, 2022, 100% (75) of the mirrors were replaced on 7A and 7B with the ligature resistant framed mirrors.

[60] The OIG reviewed evidence sufficient to demonstrate that healthcare system staff completed improvement actions, and therefore, closed the recommendations before publication of the report.

Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives

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."[61] 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."[62]

VHA implemented various evidence-based approaches to reduce veteran suicides, including 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.[63] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from emergency departments or urgent care centers and receive "structured post-discharge follow-up to facilitate engagement in outpatient mental health care."[64] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from the Emergency Department or urgent care center and follow-up within seven days of discharge.

To determine whether VHA facility staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 50 randomly selected patients who were seen in the Emergency Department or urgent care center from December 31, 2020, through August 1, 2021.

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

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

[63] 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.)

[64] Deputy Under Secretary for Health for Operations and Management memo, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives," October 17, 2019. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions," October 1, 2021.)

Mental Health Findings and Recommendations

The OIG made no recommendations.

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 in their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided eight 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 eight OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Executive Director, Chief of Staff, and Deputy Health System Director. 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	• Leaders conduct institutional disclosures for all applicable sentinel events.
Quality, Safety, and Value	• Staff complete final peer reviews within 120 calendar days, or the Executive Director approves a written extension request. • For all patient safety events assigned an actual or potential safety assessment code score of three, the Patient Safety Manager conducts an individual root cause analysis or includes the events in an aggregate review.
Medical Staff Privileging	• Service chiefs use Focused Professional Practice Evaluation criteria that are defined in advance and accepted by the practitioners. • The Medical Executive Committee reviews professional practice evaluations for licensed independent practitioners' privileging requests and documents the review in meeting minutes. • Service chiefs establish service-specific criteria for reprivileging decisions. • Service chiefs recommend reprivileging based, in part, on Ongoing Professional Practice Evaluations completed by practitioners with similar training and privileges.
Environment of Care	• Staff identify and minimize physical environmental risks to reduce suicide or suicide attempts in acute inpatient mental health units.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• None

Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 9.[1]

Table B.1. Profile for Tennessee Valley Healthcare System (626) (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	$930,797,230	$1,149,930,293	$1,252,876,627
Number of:			
• Unique patients	105,430	104,438	107,010
• Outpatient visits	1,406,384	1,324,144	1,493,773
• Unique employees§	3,948	3,928	4,046
Type and number of operating beds:			
• Community living center	178	178	162
• Domiciliary	34	20	20
• Medicine	123	123	123
• Mental health	68	68	68
• Surgery	25	25	25
Average daily census:			
• Community living center	208	152	124
• Domiciliary	26	17	7
• Intermediate	1	0	1
• Medicine	72	63	65
• Mental health	39	37	30

[1] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high volume, high risk patients, most complex clinical programs, and large research and teaching programs." "Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). 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 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Average daily census cont.:			
• Surgery	19	17	17

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 8, 2023

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

Subj: Comprehensive Healthcare Inspection of the Tennessee Valley Healthcare System in Nashville

To: Director, Office of Healthcare Inspections (54CH01)

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 the Tennessee Valley Healthcare System in Nashville. I concur with the action plans submitted by the Tennessee Valley VA Medical Center Director.
2. We thank the OIG for the opportunity to review and respond to the Draft Report: Comprehensive Healthcare Inspection of the Tennessee Valley Healthcare System in Nashville.

(Original signed by:)

Brandon Weiss for
Gregory Goins, FACHE
Network Director, VISN 9

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: February 28, 2023

From: Executive Director, Tennessee Valley Healthcare System in Nashville (626/00)

Subj: Comprehensive Healthcare Inspection of the Tennessee Valley Healthcare System in Nashville

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

1. Thank you for the opportunity to review and respond to the OIG draft report of the “Comprehensive Healthcare Inspection of the Tennessee Valley Healthcare System in Nashville.”
2. Our responses to the report recommendations are attached. We have been actively working to address the recommendations since the conclusion of the Office of the Inspector General’s (CHIP) review. We appreciate the perspective from the OIG evaluation and have taken further action to strengthen and improve our medical center processes. Implementation of the recommendations are still in progress.

(Original signed by:)

Daniel L. Dücker, MSS, M.Ed.
Executive Director

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