DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Central Texas Veterans Health Care System in Temple

CHIP REPORT | REPORT #22-00041-105 | May 9, 2023

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Figure 1. *Central Texas Veterans Health Care System in Temple.*
Source: https://www.va.gov/central-texas-health-care/.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
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 Central Texas Veterans Health Care System, which includes the Olin E. Teague Veterans' Center in Temple, the Doris Miller VA Medical Center in Waco, and multiple outpatient clinics in central Texas. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure 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 virtual inspection of the Central Texas Veterans Health Care System during the week of February 7, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration 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 two recommendations to the Executive Director and Chief of Staff in the following areas of review: Leadership and Organizational Risks and Medical Staff Privileging. These results are detailed throughout the report sections and summarized in appendix A on page 21.

Conclusion

The OIG issued two recommendations for improvement to the Executive Director and Chief of Staff. The number of recommendations should not be used as a gauge for the overall quality of care provided at this 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 24–25, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

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

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

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

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

[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 Central Texas Veterans Health Care System includes the Olin E. Teague Veterans' Center in Temple, the Doris Miller VA Medical Center in Waco, and multiple outpatient clinics in central Texas. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from May 21, 2018, through February 11, 2022, the last day of the unannounced multiday evaluation.[5] Following the virtual inspection, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

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

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

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

[5] The OIG's last comprehensive healthcare inspection of the Central Texas Veterans Health Care System occurred in May 2018. The Joint Commission performed hospital, behavioral health care, home care, and laboratory accreditation reviews in April 2021.

[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 Executive Director (Director), Associate Director (Chief Operating Officer), Assistant Director–Austin, Assistant Director–Waco, Associate Director for Patient Care Services, Chief of Staff, and Deputy Director. 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 team had worked together for about one month since the appointment of the Deputy Director. The Chief of Staff had served in the role for over seven years, the Associate Director for almost five years, and the Assistant Director–Waco for over five years. The Director and Associate Director for Patient Care Services had been in their positions for more than two years, and the Assistant Director–Austin for under two years. To help assess the executive leaders' engagement, the OIG interviewed the Director, Chief of Staff,

[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.

Associate Director for Patient Care Services, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $1,083,244,971 had increased by approximately 4 percent compared to the previous year's budget of $1,044,784,511.[10] The Director stated that the increase allowed leaders to hire additional staff and fund clinics in Killeen and Copperas Cove, Texas. The Associate Director stated that the increased funds allowed leaders to hire more nurses and Environmental Management Service staff; buy furniture and equipment to replace items such as x-ray machines that were beyond their life span; modernize the infrastructure by removing wallpaper, painting walls, and installing wood-grain flooring throughout the system; and renovate warehouses to serve as workspaces for staff who had been in temporary structures. The Associate Director also reported increasing salaries for nurses.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] The instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

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.[12]

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

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

[12] 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).

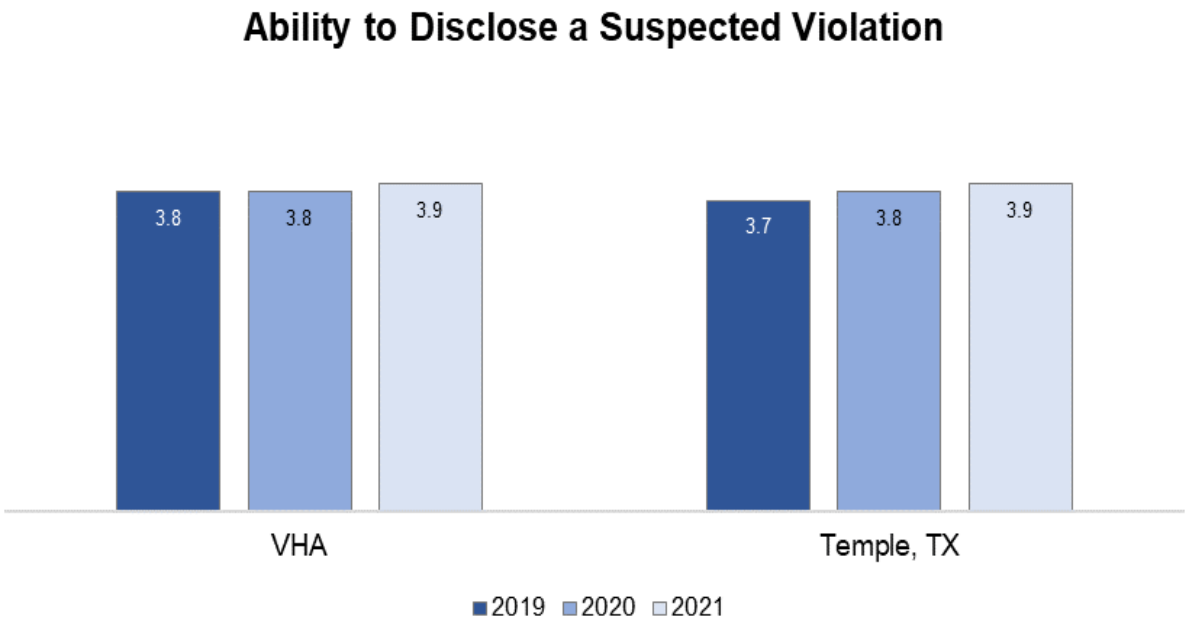

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed December 7, 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.[13]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from October 1, 2017 (FY 2018), through August 31, 2021 (FY 2021). Figures 3–5 provide survey results for VHA and the healthcare system over time.[15]

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

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

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

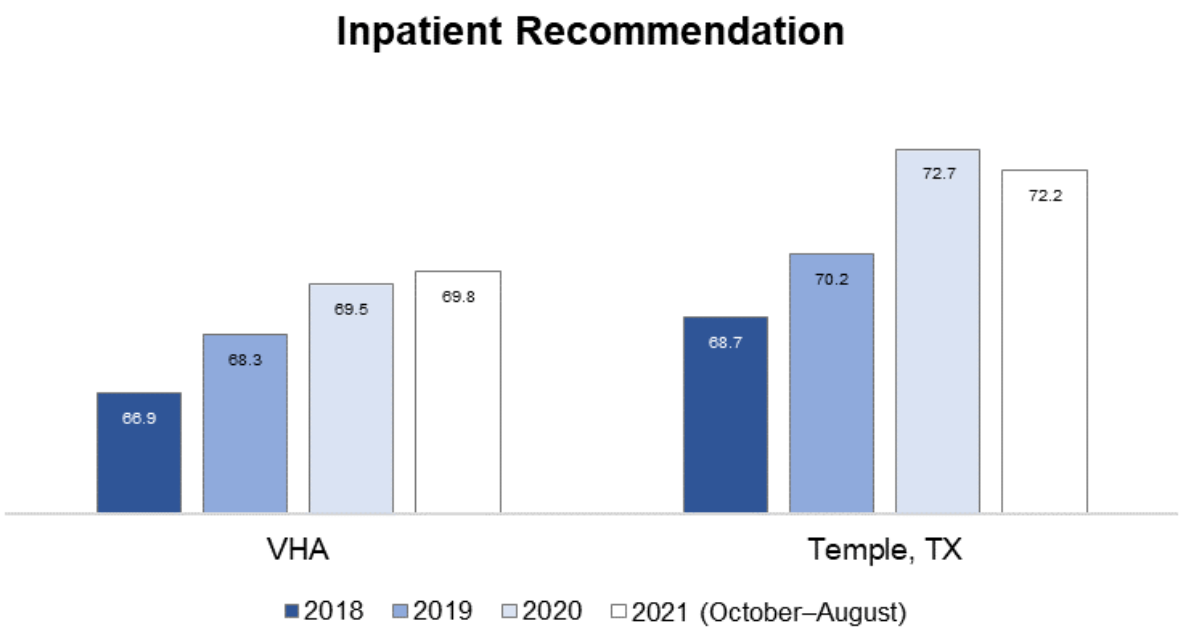

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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

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

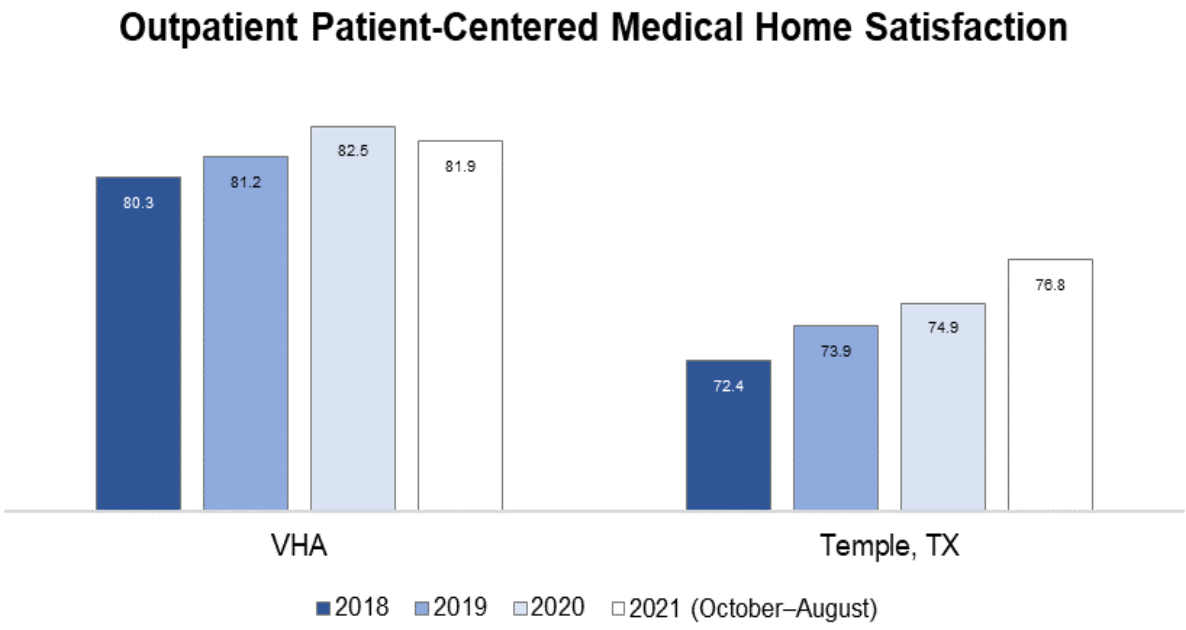

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

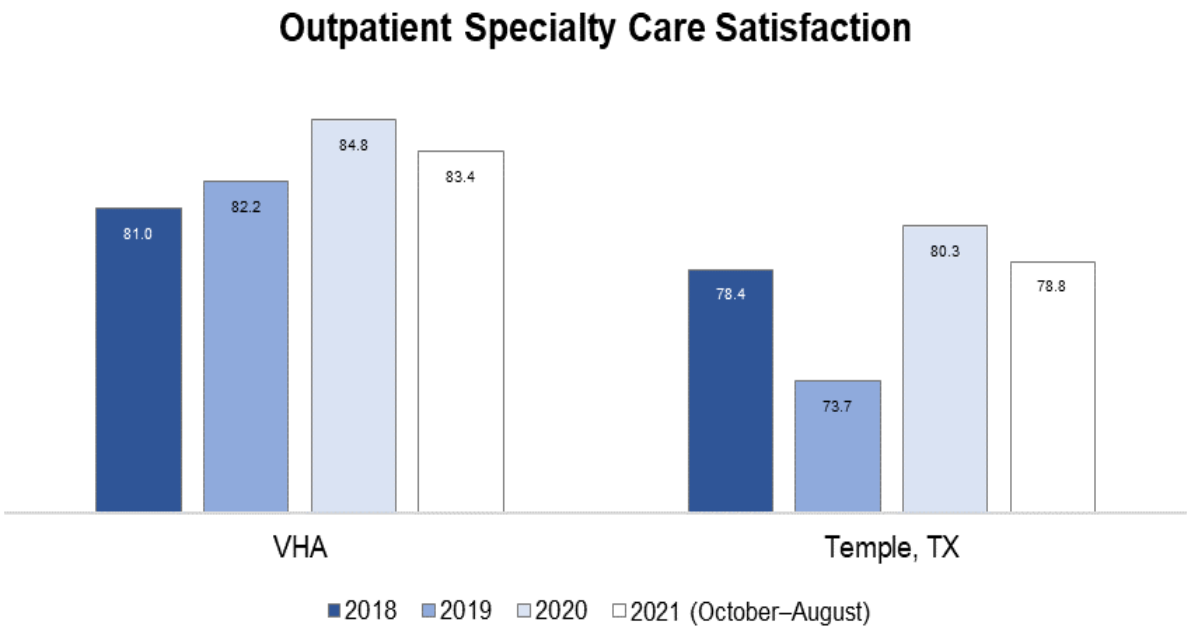

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[16] 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."[17] 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."[18] 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

[16] 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/.

[17] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

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

affected by an adverse event resulting from a systems issue."[19] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The OIG requested adverse patient safety events that occurred since May 21, 2018, the prior OIG CHIP site visit.

Table 1. Adverse Patient Safety Events

Factor	Number of Occurrences
Sentinel Events	7
Institutional Disclosures	12
Large-Scale Disclosures	0

Source: Central Texas Veterans Health Care System's Patient Safety Nurse Manager and Risk Management Program Assistant.

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.[20] 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.[21]

The Director described having a series of daily huddles with the leadership team and Quality, Safety, Value staff to discuss medical concerns, patient safety issues, and any other matters that might affect operations (such as equipment, supplies, and staffing). The Director explained that after the initial huddle, each executive leader held simultaneous meetings with their staff to discuss problems, and then reconvened with the leadership team to determine the best courses of action to address serious matters. The Director added that when the Patient Safety Manager reports patient safety events to the leadership team, they are subsequently reported to the Quality Safety & Value Executive Board. Additionally, quality staff constantly analyze data to improve patient care. The Director also stated that for serious adverse events, the Chief Quality, Safety, Value notified executive leaders by phone or in person, and the Chief of Staff determined when an institutional disclosure was warranted.

[19] VHA Directive 1004.08.

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

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

Although the Director spoke knowledgeably about the adverse event reporting process, the OIG noted concerns with leaders conducting institutional disclosures. These concerns are discussed in greater detail below.

Leadership and Organizational Risks Findings and Recommendations

VHA requires leaders to conduct an institutional disclosure when an adverse event causes or may cause the patient's death or serious injury.[22] The OIG reviewed the seven sentinel events and 12 institutional disclosures of adverse events that occurred since May 21, 2018. The OIG determined that two suicide events deserved additional evaluation and referred them to the OIG's hotline management team for review. Additionally, the OIG found that leaders did not conduct an institutional disclosure for two of the sentinel events that may have contributed to the patient's death.

Failure to perform an institutional disclosure can reduce patients' trust in the organization. The Assistant Chief, Quality, Safety, Value stated that there was an absence of communication between the Patient Safety Manager and the Risk Manager, who ensures compliance for conducting institutional disclosures.

Recommendation 1

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

[22] VHA Directive 1004.08.

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response: The Director evaluated this recommendation and did not identify any additional reasons for noncompliance. To improve communication, weekly huddles were instituted between Patient Safety and Risk Management increasing awareness of events being investigated as potential sentinel events. Additionally, in April 2022, Patient Safety and Risk Management developed a tracking mechanism using a shared spreadsheet to track institutional disclosure (ID) by sentinel event. Working with the Chief of Staff, Risk Management assisted in the completion of IDs for all sentinel events identified by Patient Safety since January 1, 2022. The Chief Quality, Safety & Value will monitor monthly ID compliance by sentinel event to ensure the facility meets its target of 90 percent compliance for six consecutive months. The numerator will be the number of sentinel event-driven IDs. The denominator will be the number of sentinel events. All IDs are reported by Risk Management quarterly through the Patient Safety Committee which is directly overseen by the Quality Safety & Value Executive Board and is chaired by the Director.

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."[23] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[25]

To determine whether staff at VHA facilities have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system's committee responsible for oversight of healthcare operations and its ability to review data and ensure 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.[26] 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."[27] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[28]

Finally, the OIG assessed the healthcare system's culture of safety.[29] 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, peer reviews, patient safety reports, and other relevant information.

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

[24] 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.)

[25] VHA Directive 1100.16.

[26] 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.

[27] VHA Directive 1190.

[28] VHA Directive 1190.

[29] 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

The OIG made no recommendations.

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."[30] 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."[31]

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.[32] LIPs are granted clinical privileges and must be reprivileged prior to their expiration.[33]

VHA defines the Focused Professional Practice Evaluation as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[34] The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[35] 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.[36]

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.[37] 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

[30] 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.)

[31] VHA Handbook 1100.19.

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[38]

The OIG interviewed key managers and selected and reviewed Focused Professional Practice Evaluations and OPPEs of LIPs, including solo or few LIPs.[39]

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to monitor privileged practitioners on an ongoing basis to help identify practice trends that may adversely affect quality of care.[40] Of the solo or few LIPs' evaluations submitted for review, the OIG found that most lacked evidence of OPPE completion. Additionally, the OIG did not find evidence that two solo or few LIPs had a completed OPPE since September 30, 2020, and six had no evidence of a completed OPPE beginning the third quarter of FY 2021. This may delay the identification of professional practice trends and adversely affect quality of care and patient safety.

The Chief of Staff cited difficulties in obtaining external reviewers from other sites to complete evaluations for solo or few LIPs. The Chief of Staff further explained that VISN leaders had not yet assigned a reviewer to complete some of the OPPEs, and reviewers did not always complete the evaluations even when they were assigned.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs complete Ongoing Professional Practice Evaluations.

[38] 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.

[39] 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.

[40] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: December 30, 2023

Healthcare system response: The Chief of Staff evaluated this recommendation and did not identify any additional reasons for noncompliance. As of February 2022, VISN 17 established an external peer review process using a SharePoint portal. Central Texas Veterans Health Care System is using this SharePoint portal to request external reviews for all solo and "few providers." This tool will assist in tracking the time from entry of the request to completion of the external review. Credentialing & Privileging Manager in collaboration with the VISN 17 Credentialing and Privileging Program Manager will provide prompts to the reviewing facility to ensure external reviews are completed timely and made available to the service chief. Turnaround times on external reviews will be monitored closely and will be escalated as needed for expedition through the Central Texas Veterans Health Care System and VISN 17 Chief of Staff. In addition, as of May 2022 a checklist was initiated for confirming the period of review, service chief signature, and ensuring that required content is documented on all OPPE templates. The Credentialing & Privileging Manager will use this checklist for monthly monitoring of OPPE completion by service chiefs to ensure the facility meets its target of 90 percent compliance for six consecutive months. The numerator will be the number of completed OPPEs with all required content. The denominator will be the total number of OPPEs due. OPPE compliance data will be presented monthly by the Credentialing & Privileging Manager to the Professional Standard Board with oversight by the Medical Staff Executive Committee, which is chaired by the Chief of Staff.

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.[41] 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 VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards.

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.[42] 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.[43]

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

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[41] 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.)

[42] 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.

[43] 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.

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."[44] 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."[45]

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.[46] 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."[47] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from emergency departments or urgent care centers 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 48 randomly selected patients who were seen in the emergency department from December 31, 2020, through August 1, 2021.

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

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

[46] 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.)

[47] 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 at their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided two 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 two OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Executive Director and Chief of Staff. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• Leaders conduct institutional disclosures for all applicable sentinel events.
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs complete Ongoing Professional Practice Evaluations.
Environment of Care	• None
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 high complexity (1a) affiliated healthcare system reporting to VISN 17.[1]

Table B.1. Profile for Central Texas Veterans Health Care System (674) (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	$780,280,602	$1,044,784,511	$1,083,244,971
Number of:			
• Unique patients	110,675	108,660	109,740
• Outpatient visits	1,329,440	1,218,648	1,297,233
• Unique employees§	3,606	3,817	3,827
Type and number of operating beds:			
• Blind Rehabilitation	11	11	11
• Community living center	194	194	194
• Domiciliary	215	230	179
• Medicine	67	71	71
• Mental health	40	40	40
• Residential rehabilitation	9	9	9
• Surgery	19	19	19
Average daily census:			
• Blind rehabilitation	7	3	2
• Community living center	176	135	84
• Domiciliary	204	96	28
• Medicine	50	43	57
• Mental health	29	24	25
• Residential rehabilitation	7	7	4

[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: • Surgery	10	8	7

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

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

**October 1, 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 27, 2023

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

Subj: Comprehensive Healthcare Inspection of the Central Texas Veterans Health Care System in Temple

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

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

Thank you for the opportunity to respond to the Comprehensive Healthcare Inspection of the Central Texas VA Health Care System in Texas. VA remains committed to honoring our Nation's Veterans by ensuring a safe environment to deliver exceptional healthcare.

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

(Original signed by:)

Wendell E. Jones
VISN 17 Network Director

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 27, 2023

From: Executive Director, Central Texas Veterans Health Care System (674/00)

Subj: Comprehensive Healthcare Inspection of the Central Texas Veterans Health Care System in Temple

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

1. Thank you for conducting the Comprehensive Healthcare Inspection (OIG) review during the week of February 7, 2022, at the Central Texas Veterans Health Care System.
2. The recommendations have been reviewed. Central Texas concurs with all recommendations.
3. A plan of action for each of the two recommendations is attached. The two plans of action have been carefully analyzed, implemented, and monitored through satisfactory completion.
4. I have reviewed the document and concur with the response as submitted.

(Original signed by:)

Mr. Michael L. Kiefer, MHA, FACHE
Executive Director, Central Texas Veterans Health Care System

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	Frank Keslof, MHA, EMT, Team Leader Tasha Felton-Williams, DNP, ACNP Miquita Hill-McCree, MSN, RN Sheeba Keneth, MSN/CNL, RN Megan Magee, RN
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Reynelda Garoutte, MHA, BSN 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 Erika Terrazas, MS Elizabeth Whidden, MS, APRN Thomas Wong, DO Jarvis Yu, MS

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