DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Loma Linda Healthcare System in California

CHIP REPORT | REPORT #22-00048-120 | MAY 24, 2023

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Figure 1. *Jerry L. Pettis Memorial Veterans' Hospital of the VA Loma Linda Healthcare System in California.*

Source: https://www.va.gov/loma-linda-health-care/locations/.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Loma Linda Healthcare System, which includes the Jerry L. Pettis Memorial Veterans' Hospital and multiple outpatient clinics in California. 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 VA Loma Linda Healthcare System during the week of February 28, 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 five recommendations to the Director and Chief of Staff in the following areas of review: Leadership and Organizational Risks; Quality, Safety, and Value; and Medical Staff Privileging. These results are detailed throughout the report and summarized in appendix A on page 24.

Conclusion

The OIG issued five recommendations for improvement to the 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 moving forward. The recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Interim System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 26–27, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 VA Loma Linda 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)

[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 VA Loma Linda Healthcare System includes the Jerry L. Pettis Memorial Veterans' Hospital and associated outpatient clinics in California. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from March 13, 2017, through March 4, 2022, 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 Interim 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 VA Loma Linda Healthcare System occurred in March 2017 (Clinical Assessment Program review). The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in February 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 Director, Assistant Director, Associate Director of Operations, Associate Director of Resources, Associate Director of Patient Care Services, and Chief of Staff.[10] The Chief of Staff and Associate Director of Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, four of the executive leaders had worked together for approximately two years; the Director had served in the role since March 2019, and the three other leaders had been in their positions for more than two years. To help assess the executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Associate Director of

[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] The associate director of resources position was vacated on October 10, 2021; according to the Director, the permanent Assistant Director then served in the role in an acting capacity, and the Chief of Prosthetics was detailed to the assistant director position.

Patient Care Services, and Associate Director of Operations 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 $928,595,356 had increased by 10 percent compared to the previous year's budget of $843,684,231.[11] The Director reported that leaders prioritized staffing and offered competitive salaries to help with recruitment and retention. The leader also stated that community care costs had increased.[12] The Associate Director of Operations told the OIG that leaders used much of the funding in the past two years for COVID-19-related expenses and some for contracted and additional staff to meet patient care needs. The Associate Director of Operations also explained that leaders upgraded some units to increase the number of patient care rooms with negative air flow.

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 for 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 (see figure 2).[15]

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

[12] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed December 7, 2022, https://www.va.gov/communitycare/.

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

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

[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).

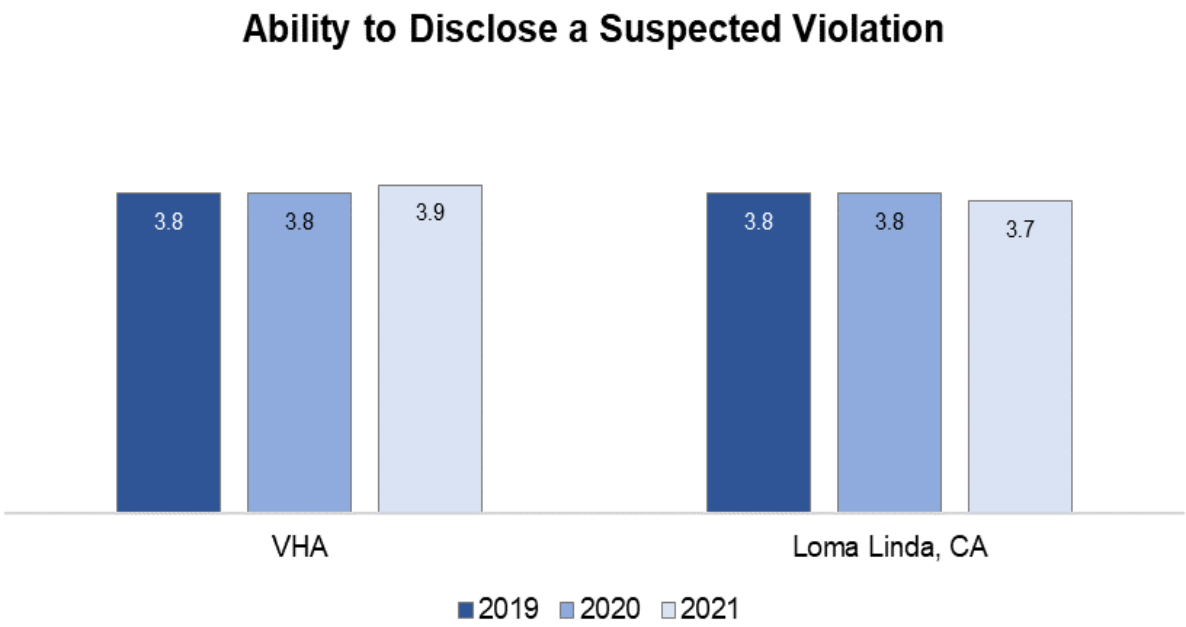

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed January 25, 2022).

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 from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the healthcare system over time.[18]

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

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

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

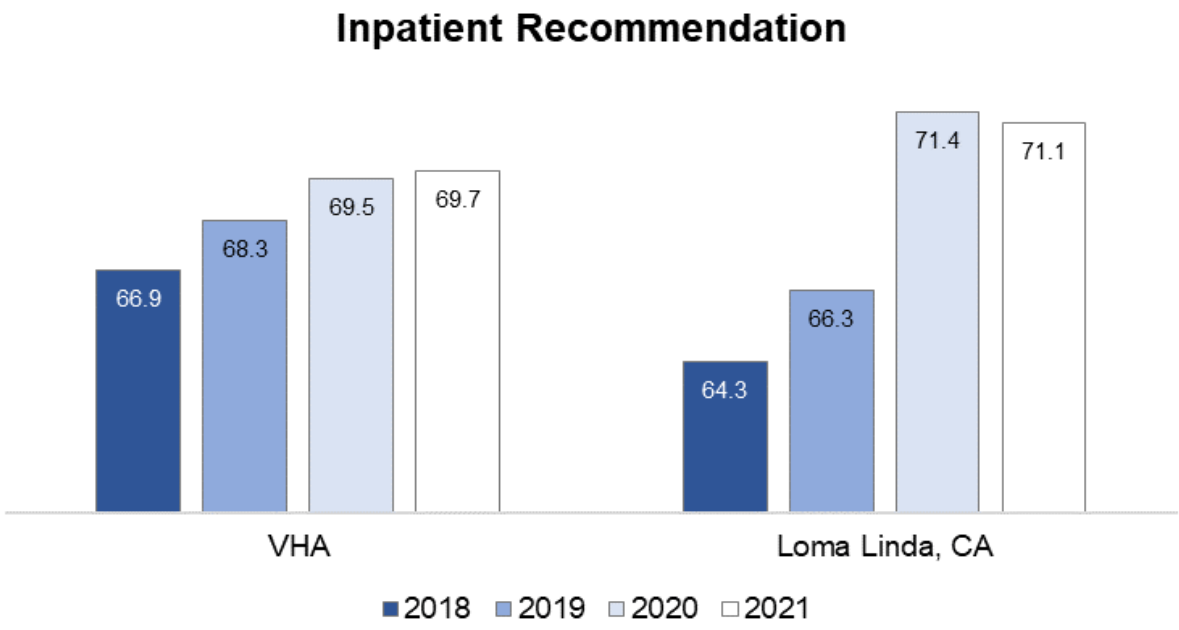

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

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

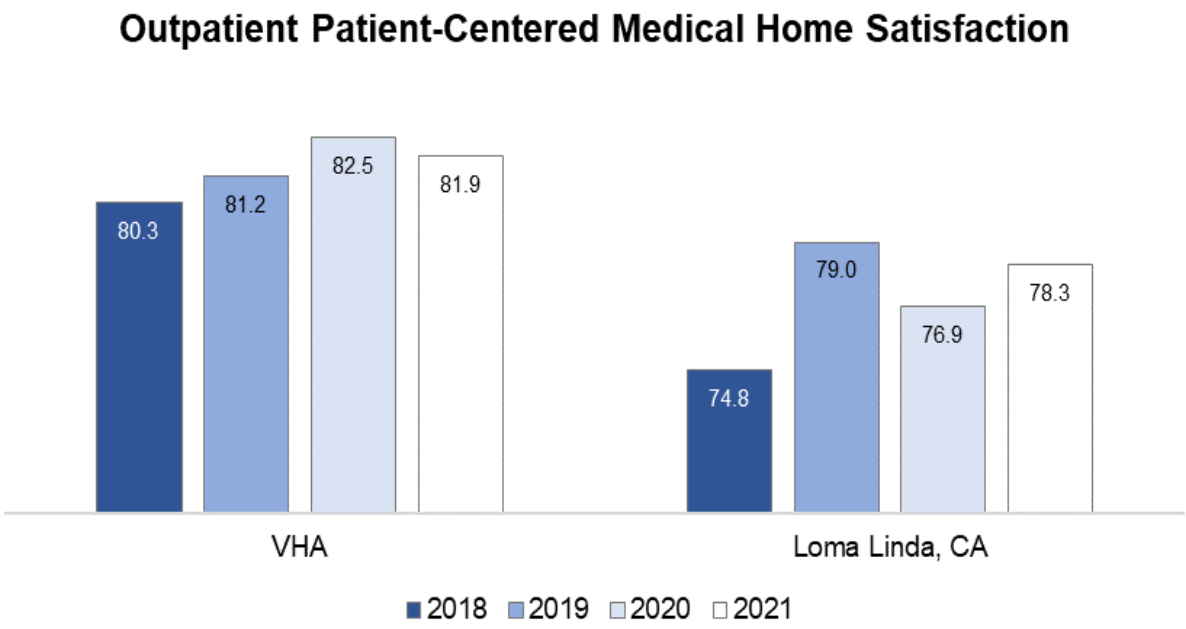

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

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

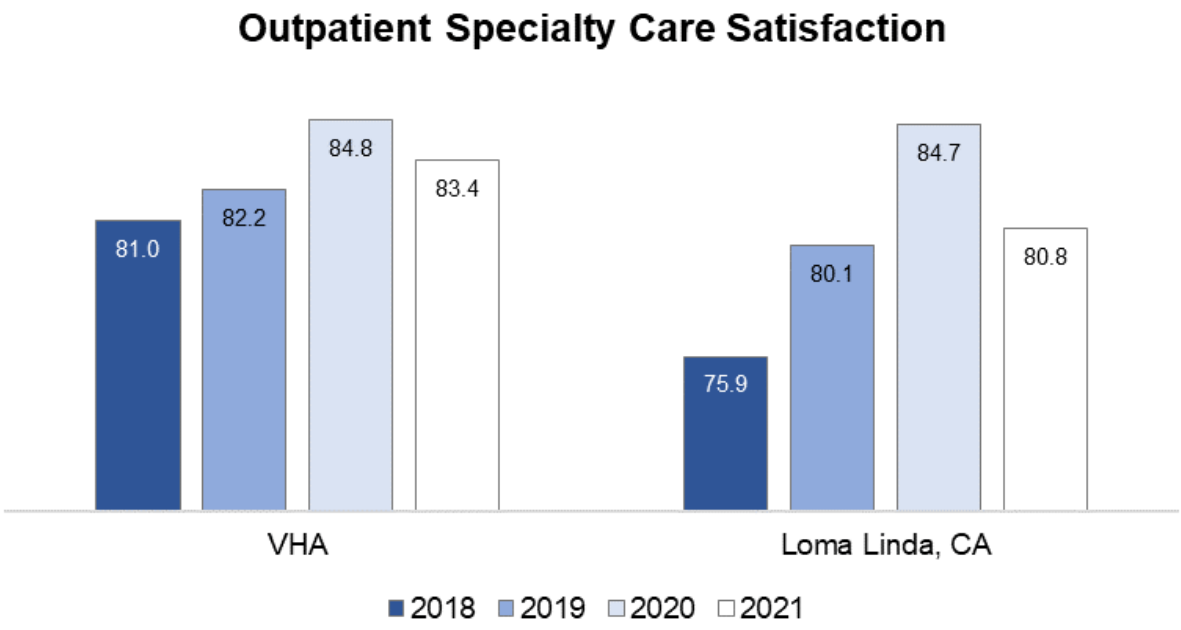

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 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

[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.

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 Director explained that staff reported patient safety events during tiered huddles and through reports from the nursing officer of the day and Joint Patient Safety Reporting system.[25] To determine whether a patient safety event required an institutional disclosure, the Director relied on the Chief of Staff and Risk Manager to evaluate the level of patient harm and identify next steps. The Director also discussed a new process that started in late 2020 in which the patient safety team debriefs events that are not chartered for root cause analysis investigations.[26]

The OIG reviewed the sentinel events, institutional disclosures, and large-scale disclosures reported by healthcare system staff, which occurred since the OIG Clinical Assessment Program review in March 2017.

The OIG had concerns and observed that opportunities existed for leaders to ensure patient safety staff have processes for identifying, reviewing, tracking, and monitoring adverse events to include sentinel events. During the OIG inspection, the Director responded by contacting the VISN Quality Management Office and developing an action plan targeting staff training and development.

[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] "Joint Patient Safety Reporting (JPSR) integrates the Defense Health Agency (DHA) and Veterans Affairs (VA) patient safety data collection and analysis processes to create a single data source for quantitative and comparative data analysis." Defense Health Agency, "Fact Sheet JPSR Joint Patient Safety Reporting," August 2021.

[26] A root cause analysis is a focused review to identify the actual system- and process-related contributing factors of the event. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

Leadership and Organizational Risks Findings and Recommendations

VHA states that sentinel events "signal the need for immediate investigation and response" and reviewable events have required responses.[27] VHA requires that when "an adverse event has resulted in or is reasonably expected to result in death or serious injury, an institutional disclosure must be performed regardless of when the event is discovered."[28] VHA also requires leaders to document the disclosure in the patient's electronic health record. The OIG found that leaders did not complete institutional disclosures for all sentinel events that may have contributed to patients' death. Staff were unable to provide reasons why leaders did not consistently complete the disclosures.

Recommendation 1

1. The Director evaluates and determines reasons for noncompliance and ensures leaders evaluate sentinel events and conduct institutional disclosures when criteria are met.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: In consultation with Quality and Patient Safety staff, the Director reviewed the recommendation and implemented improvements in the institutional disclosure process. On April 12-13, 2023, the Risk Manager reviewed VHA Directive 1004.08, Disclosure of Adverse Events, with the Chief of Staff, Associate Director of Patient Care Services and Patient Safety Managers to ensure alignment with institutional disclosure process. Upon discovery of a sentinel event, Quality and Patient Safety staff will inform the Director, Chief of Staff and/or the Associate Director of Patient Care Services. If an institutional disclosure is warranted, the decision will be discussed and made by the Director, Chief of Staff and/or Associate Director of Patient Care Services. The Quality and Patient Safety staff will document the indication for institutional disclosure in a secure database. In addition, Quality and Patient Safety staff meet monthly to review all adverse events and to ensure all components of the process have taken place. Quality and Patient Safety staff will monitor and report monthly compliance with the completion of appliable institutional disclosures to the Quality Council. Monitoring will continue until 90 percent compliance for six consecutive months is achieved.

[27] VHA Handbook 1050.01.

[28] VHA Directive 1004.08.

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."[29] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[30] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[31]

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.[32] 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."[33] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[34]

Finally, the OIG assessed the healthcare system's culture of safety.[35] 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.

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

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

[31] VHA Directive 1100.16.

[32] 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.

[33] VHA Directive 1190.

[34] VHA Directive 1190.

[35] 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 13, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, 11 peer reviews assigned a final level of 3, patient safety reports, and other relevant information.[36]

Quality, Safety, and Value Findings and Recommendations

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."[37] The OIG found that for all events with an actual or potential safety assessment code score of three, staff did not complete an individual root cause analysis or include the event in an aggregated patient safety review. The lack of completed root cause analyses diminishes staff's ability to identify and mitigate system vulnerabilities, which is instrumental in reducing patient harm. The OIG interviewed two patient safety managers who reported not receiving formal training since being hired—one in May 2020 and the second in May 2021. One patient safety manager reported having limited Joint Patient Safety Reporting system and root cause analysis training from the VISN Patient Safety Officer and believing that documentation in the reporting system was sufficient, and these cases required no additional action.

Recommendation 2

2. The Director evaluates and determines any additional reasons for noncompliance and ensures that for all events assigned an actual or potential safety assessment code score of three, staff either complete an individual root cause analysis or include the event in an aggregated patient safety review.

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

[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. An aggregated review is a comparison of data used to determine if further action is required. VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Business Rules and Guidebook*, July 2020. VHA National Center for Patient Safety issued a new guidebook in November 2021, *Guidebook for JPSR Business Rules and Guidance*.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: The Director evaluated and determined no additional reasons for noncompliance. The following plan of correction has been implemented: Patient Safety Managers complete review of all Joint Patient Safety Reports (JPSRs) as per VHA National Center for Patient Safety JPSR Guidebook, dated December 2022. Upon assessing an event with an actual or potential safety assessment code score of three, the Patient Safety Manager immediately notifies the Director, makes recommendations, and seeks concurrence for chartering an individual Root Cause Analysis (RCA) or include the event in an aggregated patient safety review. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. Compliance will be reported at Quality Council through the governance structure.

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."[38] 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."[39]

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

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."[42] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[43] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[44]

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.[45] 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

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

[39] VHA Handbook 1100.19.

[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 Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[46]

The OIG interviewed key staff and managers and selected and reviewed the privileging folders of select medical staff members who had an FPPE or Ongoing Professional Practice Evaluation completed from January 1, 2021, through December 31, 2021.

Medical Staff Privileging Findings and Recommendations

VHA requires that FPPE criteria be "defined in advance, using objective criteria accepted by the practitioner."[47] The OIG reviewed six LIPs' folders and found they all lacked evidence the LIPs were aware of and had accepted the evaluation criteria before clinical managers initiated the FPPE process. This could have resulted in LIPs misunderstanding evaluation expectations. The LIP lead in the credentialing and privileging office reported sending the FPPE criteria to the LIPs via email, with instructions to return the document to their service chiefs and review the criteria during orientation, but not maintaining the communication record. Additionally, service chiefs reported having verbal conversations with new LIPs, which were not documented.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures clinical managers use Focused Professional Practice Evaluation criteria that are defined in advance and accepted by the practitioner.

[46] 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.

[47] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. VA Loma Linda Healthcare System updated the Focused Professional Practice Evaluation (FPPE) Summary Report form to include Service/Section specific criteria. The FPPE Summary Report form was reviewed and voted on and approved at the Professional Standard Board (PSB) on October 18, 2022. Subsequently, the FPPE Summary Report form was reviewed and approved by the Medical Executive Council (MEC) also on October 18, 2022. Clinical Service Chiefs started using the new FPPE Summary Report form on November 1, 2022. Clinical Service Chiefs are responsible to ensure all new practitioners are made aware of evaluation criteria in advance and will utilize the FPPE Summary Report form prior to initiating the FPPE process. The Medical Staff Office will assist the service chiefs and monitor compliance. All initial FPPE Summary Report forms will be presented at the MEC. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. Compliance will be reported at the Quality Council through the governance structure.

VHA requirements further state the "FPPE is a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[48] The OIG found that for three of the FPPEs reviewed, including one for a solo or few practitioner, clinical managers did not clearly define the time frames.[49] Defined evaluation periods allow for the timely review of practitioners' performance and ensure an efficient process. The Credentialing and Privileging Manager explained that staff did not define time frames on the FPPE documentation due to clerical errors.

[48] VHA Handbook 1100.19.

[49] 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.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain clinical managers define time frames for Focused Professional Practice Evaluations.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. VA Loma Linda Healthcare System implemented the Focused Professional Practice Evaluation (FPPE) Summary Report Form on November 1, 2022. The new FPPE Summary Report form includes defined time frames for practitioners' FPPE. The FPPE Summary Report form is used for the quality check review conducted by the Credentialing and Privileging FPPE Coordinator. All initial FPPE Summary Report forms to include the defined time frames will be presented at Professional Standard Board (PSB) and Medical Executive Council (MEC) and included in the respective meeting minutes. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. Compliance will be reported at the Quality Council through the governance structure.

VHA requires an executive committee of the medical staff to review and evaluate LIPs' re-privileging requests.[50] Additionally, committee meeting minutes must include the materials reviewed and rationale for the conclusion. The committee's recommendation is then submitted to the Director for approval.[51] For three of the LIPs granted continuations of privileges, the OIG did not find evidence the Medical Executive Council documented its review for two of them, or evidence of the data used to support privileging recommendations for the third LIP. Failure to properly document reviews may result in incomplete evidence to support the council's recommendations to the Director for approval of clinical privileges. For the LIP without evidence of data for the council's review, the Credentialing and Privileging Manager reported the council voted electronically but could not locate the documentation.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and verifies that the Medical Executive Council's meeting minutes consistently reflect the data reviewed for licensed independent practitioners' re-privileging requests and the rationale for the recommendations.

[50] VHA Handbook 1100.19. The Medical Executive Council performed this function at this healthcare system.
[51] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. Medical Executive Council (MEC) will review and evaluate all licensed independent practitioner's re-privileging requests from Professional Standards Board. MEC will ensure the re-privileging requests and the rationale for recommendations are documented in the MEC minutes. The Medical Staff Office will conduct audits of monthly MEC meeting minutes regarding proper documentation of all required elements of providers undergoing re-privileging and the rationale for recommendations. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. Compliance will be reported to the Quality Council through the governance structure.

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.[52] 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.[53]

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.[54] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times in emergencies and contribute to a safe healthcare environment.[55]

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

- Community Living Center (1 South)

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

[53] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

[54] 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.

[55] 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.

- Emergency Department
- Intensive care unit (2 SE)
- Medical and surgical inpatient units (4 SE and 4 SW)
- Mental health inpatient unit (2 NE)
- Outpatient clinic (General Surgery)
- Short stay unit (3 SW)
- Specialty care clinic (Hemodialysis Unit 4 NE)

Environment of Care Findings and Recommendations

The OIG made no recommendations.

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

Suicide prevention remains the top clinical 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."[56] 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."[57]

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.[58] 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."[59] 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 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 or urgent care center from December 31, 2020, through August 1, 2021.

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

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

[58] 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.)

[59] 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 US 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 five 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 five OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the 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 evaluate sentinel events and conduct institutional disclosures when criteria are met.
Quality, Safety, and Value	• For all events assigned an actual or potential safety assessment code score of three, staff either complete an individual root cause analysis or include the event in an aggregated patient safety review.
Medical Staff Privileging	• Clinical managers use Focused Professional Practice Evaluation criteria that are defined in advance and accepted by the practitioner. • Clinical managers define time frames for Focused Professional Practice Evaluations. • The Medical Executive Council's meeting minutes consistently reflect the data reviewed for licensed independent practitioners' re-privileging requests and the rationale for recommendations.
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 highest complexity (1a) affiliated healthcare system reporting to VISN 22.[1]

Table B.1. Profile for VA Loma Linda Healthcare System (605) (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	$750,002,200	$843,684,231	$928,595,356
Number of:			
• Unique patients	74,445	76,051	78,107
• Outpatient visits	954,129	918,625	1,038,673
• Unique employees§	2,774	2,972	3,014
Type and number of operating beds:			
• Community living center	110	110	110
• Medicine	77	77	77
• Mental health	34	34	34
• Neurology	2	2	2
• Surgery	46	46	46
Average daily census:			
• Community living center	83	55	41
• Medicine	55	45	58
• Mental health	20	17	16
• Neurology	1	1	1
• Surgery	17	16	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).*

[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.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 25, 2023

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Comprehensive Healthcare Inspection of the VA Loma Linda Healthcare System in California

To: Director, Office of Healthcare Inspections (54CH03)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) Draft Report, Comprehensive Healthcare Inspection of the VA Loma Linda Healthcare System in California.
2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted action plans of the VA Loma Linda Healthcare System.
3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(Original signed by:)

Michael Fisher
VISN 22 Network Director

Appendix D: Interim Director Comments

Department of Veterans Affairs Memorandum

Date: April 21, 2023

From: Interim Director, VA Loma Linda Healthcare System (605/00)

Subj: Comprehensive Healthcare Inspection of the VA Loma Linda Healthcare System in California

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of the VA Loma Linda Healthcare System in California. I concur with the findings and recommendations in the report.
2. VA Loma Linda Healthcare System remains committed to ensuring our Veterans receive exceptional health care.

(Original signed by:)

Bryan E. Arnette, FACHE

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