DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System in Prescott

CHIP REPORT | REPORT #22-00052-121 | MAY 23, 2023

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Figure 1. *Bob Stump VA Medical Center of the Northern Arizona VA Health Care System in Prescott.*

Source: https://www.va.gov/northern-arizona-health-care/locations/.

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Northern Arizona VA Health Care System, which includes the Bob Stump VA Medical Center in Prescott and multiple outpatient clinics in Arizona. 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 Northern Arizona VA Health Care System during the week of March 14, 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 six recommendations to the Medical Center Director, Chief of Staff, and Associate Director in the following areas of review: Medical Staff Privileging and Environment of Care. The results are detailed in those report sections and summarized in appendix A on page 23.

Conclusion

The OIG issued six recommendations for improvement to the Medical Center Director, Chief of Staff, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care 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 Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 25–26, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendation 5 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

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

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

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

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

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

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

[3] Danae F. Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The Northern Arizona VA Health Care System includes the Bob Stump VA Medical Center (Prescott) and associated outpatient clinics in Arizona. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from February 16, 2019, through March 18, 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 Medical Center Director's responses to the report recommendations appear within the relevant topic areas. The OIG accepted the actions 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 Northern Arizona VA Health Care System occurred in February 2019. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in October 2020.

[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 Medical Center Director (interim Director), Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director (acting Associate Director). The Chief of Staff and ADPCS oversaw patient care, which included managing service line and program chiefs.

At the time of the OIG inspection, three members of the executive team (interim Director, Chief of Staff, and ADPCS) had worked together for about seven months in their various roles at the healthcare system. The interim Director, who was appointed in February 2022, previously served in the associate director position. Another staff member has also served in the associate director position since the appointment of the interim Director. The ADPCS, the most tenured member, was appointed in April 2019. The Chief of Staff, permanently assigned in July 2021, served in the deputy chief of staff position prior to the appointment. To help assess the executive leaders'

[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.

engagement, the OIG interviewed the interim Director, Chief of Staff, ADPCS, and acting 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 $367,102,487 had increased by approximately 17 percent compared to the previous year's budget of $313,454,727.[10] The interim Director stated the extra funds allowed leaders to hire additional staff and pay for the increased cost of natural gas. The acting Associate Director reported using funds to cover community care costs, open a new radiology center, and purchase a new magnetic resonance imaging machine.

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.[12] 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.[13]

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

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

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

[13] 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).

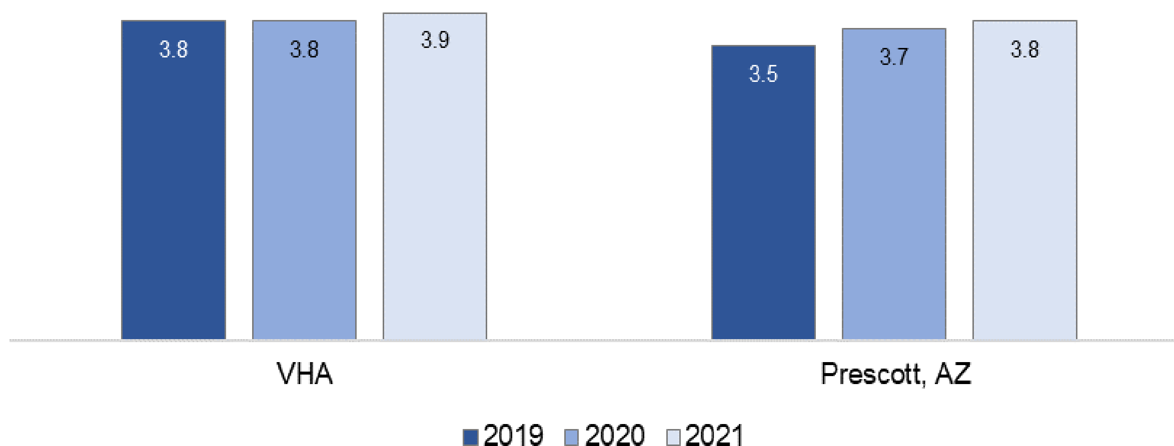

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed February 14, 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.[14]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] 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.[16]

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

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

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

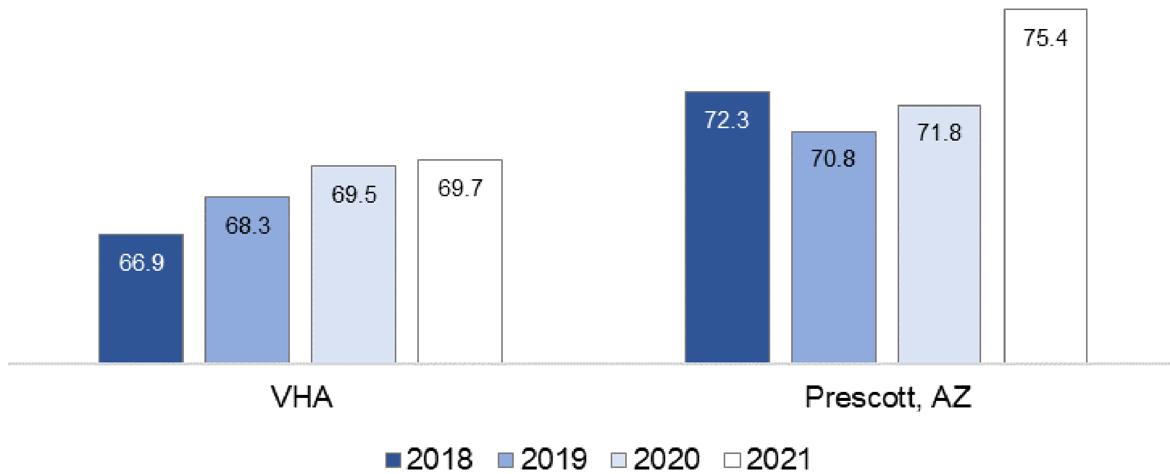

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

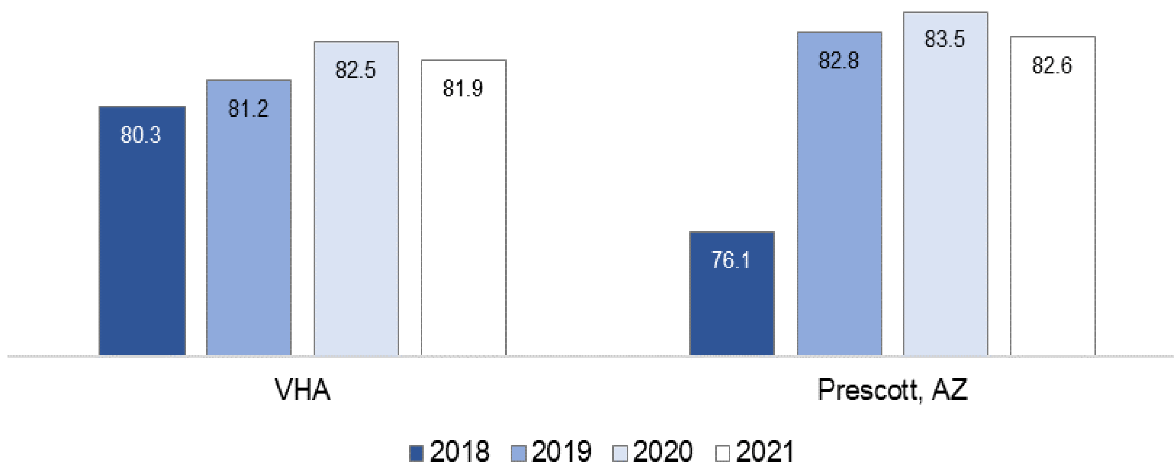

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

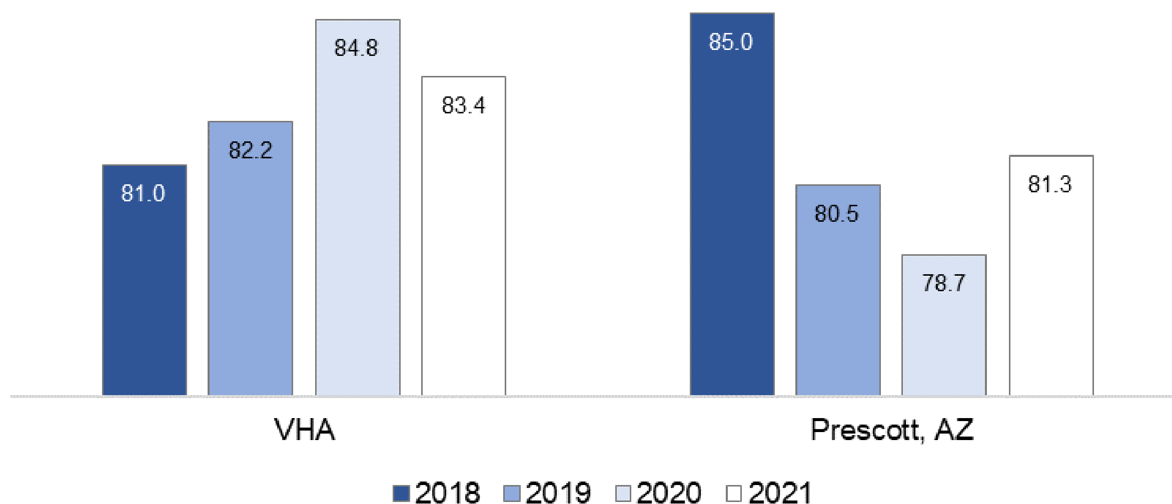

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.[17] 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."[18] 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."[19] 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

[17] 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/.

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

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

affected by an adverse event resulting from a systems issue."[20] 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.[21] 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.[22]

The interim Director stated the executive leadership team met with quality management staff to discuss patient safety events during morning meetings. The interim Director described encouraging staff to report all patient safety events through the patient safety reporting system and using a four-tiered huddle process to discuss and address patient safety events, starting at the service level and rising to the executive leadership team. The OIG reviewed sentinel events, institutional disclosures, and large-scale disclosures that occurred from February 16, 2019 (the prior OIG CHIP site visit), through March 13, 2022.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[20] VHA Directive 1004.08.

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

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

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 staff at its facilities to 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 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.[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 for a limited time and must be reprivileged prior to their expiration.[33]

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."[34] The FPPE 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 reviewed selected LIPs' FPPEs and OPPEs, including those for solo or few practitioners.[39]

Medical Staff Privileging Findings and Recommendations

VHA requires FPPE criteria to "be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process and approved by the Director."[40] The OIG found that two FPPEs lacked evidence the LIPs were aware of and had accepted the evaluation criteria before service chiefs initiated the FPPE process. When LIPs are not informed of the evaluation criteria, they may not understand FPPE expectations. The Specialty and Diagnostics Service Line Manager reported that service chiefs discussed the FPPE criteria with LIPs but was unaware that documentation of the discussion was necessary.

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs define Focused Professional Practice Evaluation criteria in advance using objective criteria accepted by the licensed independent practitioner.

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[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: October 31, 2023

Healthcare system response: Clinical service chiefs are responsible to ensure new practitioners are made aware of Focused Professional Practice Evaluations (FPPE) in advance. Clinical service chiefs and practitioners will both sign a memo attesting that the FPPE criteria has been communicated. A signed copy will be kept at the service level. Credentialing & Privileging Office staff will assist the service chiefs in monitoring compliance. The Credentialing and Privileging Manager and the Credentialing and Privileging Analyst will monitor until 90 percent compliance is achieved and sustained for six consecutive months and will report monthly to the Credentialing Committee of the Medical Executive Board.

According to VHA, service chiefs must "establish additional criteria for granting of clinical privileges within the service consistent with the needs of the service and the facility as well as within the available resources to provide these services."[41] The OIG found that some of the OPPEs lacked evidence that service chiefs established service-specific criteria. This may result in service chiefs lacking adequate data to support continued privileges. The Chief of Staff reported being unaware of the requirement until results from a VISN review indicated the facility's OPPE forms did not contain service-specific criteria.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs establish service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: Clinical service chiefs are responsible to ensure service-specific criteria are used when evaluating practitioners. In March 2022, NAVAHCS [Northern Arizona VA Health Care System] implemented service-specific clinical indicators and are currently using these criteria. Credentialing & Privileging Office staff will assist in monitoring the use of nationally mandated, service-specific clinical indicators during Ongoing Professional Practice Evaluation (OPPE) reviews. The Credentialing and Privileging Manager and the Credentialing and Privileging Analyst will monitor until 90 percent compliance is achieved and sustained for six consecutive months or one OPPE cycle and will report monthly to the Credentialing Committee of the Medical Executive Board.

[41] VHA Handbook 1100.19.

VHA requires that service chiefs' determinations to continue current privileges are based, in part, on OPPE activities such as direct observation, clinical pertinence reviews, and clinical discussions.[42] VHA also requires service chiefs to "clearly document the basis for recommendation of renewal of privileges," and an executive committee of the medical staff (known as the Medical Executive Board at this system) to recommend continuing privileges based on OPPE results.[43] Of the 20 OPPEs reviewed, the OIG found that a solo or few LIP's evaluation lacked evidence the service chief's determination to continue privileges was based on all OPPE activities. Consequently, the Medical Executive Board did not consider all OPPE results in their reprivileging decision. This resulted in the LIP continuing to deliver care without a thorough practice evaluation. The Specialty and Diagnostics Service Line Manager reported that not obtaining one OPPE form from an outside reviewer prior to the reprivileging determination was an oversight.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs base determinations to continue current privileges on Ongoing Professional Practice Evaluation activities.

Healthcare system concurred. Target date for completion: October 31, 2023 Healthcare system response: Clinical service chiefs review up to four previous Ongoing Professional Practice Evaluation (OPPE) cycles when recommending renewal of privileges. Clinical service chiefs sign the OPPE forms and applicable committee minutes and attest in VetPro that OPPE results have been reviewed and no concerns are noted. The Credentialing Committee of the Medical Executive Board also reviews the OPPEs when reviewing Clinical service chiefs' recommendations for renewing practitioners' privileges. Credentialing & Privileging Office staff will assist in monitoring OPPE review compliance upon processing practitioners for reprivileging. The Credentialing and Privileging Manager and the Credentialing and Privileging Analyst will monitor until 90 percent compliance is achieved and sustained for six consecutive months and will report monthly to the Credentialing Committee of the Medical Executive Board.

[42] VHA Handbook 1100.19.

[43] VHA Handbook 1100.19.

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.[44] 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.[45]

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

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

- Cardiology clinic (3A)

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[44] 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.)

[45] 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.

[46] 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.

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

- Community living centers (1 and 2)
- Domiciliary
- Emergency Department
- Primary care clinic (building 158)
- Telemetry unit (3B)

Environment of Care Findings and Recommendations

VHA requirements state that "if [an] item or packaging is wet, soiled, punctured, ripped or torn, [it] must be removed from storage."[48] In two patient care areas inspected, the OIG found open sterile medical supplies, such as an electrocardiogram monitoring electrode package and a portable suction filter, which could cause harm to patients and hinder access to appropriate medical treatment.[49] The Telemetry Nurse Manager, Inpatient Medical Unit acknowledged that although staff were aware of the requirement to remove open sterile products from the supply room, they did not follow procedures. Additionally, the Associate Chief Nurse, Geriatrics & Extended Care reported believing that removing one or more sterile portable suction filters from a multi-unit pack and leaving the remaining unused filters in the original packaging met the requirement.

Recommendation 4

4. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures staff remove sterile supplies from storage when the packaging is damaged or compromised.

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

[49] The OIG found these deficiencies in the telemetry unit (3B) and community living center 2.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: In March 2022, the Community Living Center (CLC) and 3B Service Line Nurse Managers and Assistant Nurse Managers educated staff on the process for one time use supplies and discarding of remaining products. The Supply Chain Technician will monitor the clean supply rooms located in 3B and CLC monthly for six consecutive months. The numerator will be the number of observations where sterile supply storage areas were found free of damaged or compromised packages. The denominator equals the number of observations for all clean supply rooms in 3B and CLC for six consecutive months. Fall outs will be reported by the Supply Chain Technician to the Supply Chain Supervisor. The Supply Chain Supervisor will then notify the 3B and CLC Nurse Managers or Assistant Nurse Managers after each inspection. There will be 20 observations per month in both 3B and CLC by the Supply Chain Technician. The Nurse Managers will report the compliance monthly to [the] Quality and Patient Safety Council until 90 percent compliance is sustained for six consecutive months.

To meet environmental cleanliness standards, The Joint Commission requires facility staff to establish and maintain a safe, suitable environment and keep areas used by patients clean.[50] The OIG observed stained ceiling tiles in two clinical areas inspected (telemetry unit (3B) and community living center 1). This resulted in a potentially unclean and unsafe patient care environment. The Chief of Safety reported that staffing shortages in the carpenter shop delayed ceiling tile replacements. Additionally, the Chief of Safety stated that community living center 1 renovations were scheduled the month following the OIG inspection, and staff will investigate the cause of the stain and replace ceiling tiles.

Recommendation 5

5. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures staff keep clinical areas in good repair and maintain a safe and clean environment throughout the healthcare system.[51]

[50] The Joint Commission, *Standards Manual*, EC.02.06.01.

[51] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: On April 24, 2023, the Chief of Facilities Management Services dedicated carpenters and entered work orders to replace the damaged or stained ceiling tiles in [the] 3B and Community Living Center (CLC) areas identified by the OIG. On April 24, 2023, the dedicated carpenters replaced the ceiling tiles in 3B and CLC and reported completion to the Chief of Facilities Management Services.

The facility would like to request closure for the recommendation prior to publication based on supporting evidence provided to the OIG.

VHA requires hospital staff to post "notices in treatment areas with overt recording that the area is subject to photography or video recording."[52] In two areas inspected, the OIG found cameras but no posted notices indicating the areas were subject to video recording.[53] Photography, video, and audio recordings conducted in treatment areas without appropriate notice may potentially violate patient privacy and interfere with patient care. The Chief of Safety reported being unaware of the need to post notices because their environment of care checklist did not include the requirement.

Recommendation 6

6. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures staff post notices in areas that are subject to photography or video recording.

Healthcare system concurred.

Target date for completion: October 31, 2023

Healthcare system response: The Chief of Police identified locations that require additional footage and signage and understood that the requirement to install the correct signage is important in meeting recent findings from the OIG. The Chief of Police placed work orders to post correct signage in the identified areas and will monitor compliance and report completion to the Quality and Patient Safety Council.

[52] VHA Directive 1078(1), *Privacy of Persons Regarding Photographs, Digital Images, and Video or Audio Recordings*, November 4, 2014, amended November 19, 2014. (VHA rescinded and replaced this directive with VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021.)

[53] The OIG identified the deficiencies in the domiciliary and Emergency Department.

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."[54] 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."[55]

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.[56] 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."[57] 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 50 randomly selected patients who were seen in the Emergency Department or urgent care center from December 31, 2020, through August 1, 2021.

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

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

[56] 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.)

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

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs define Focused Professional Practice Evaluation criteria in advance using objective criteria accepted by the licensed independent practitioner. • Service chiefs establish service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners. • Service chiefs base determinations to continue current privileges on Ongoing Professional Practice Evaluation activities.
Environment of Care	• Staff remove sterile supplies from storage when the packaging is damaged or compromised. • Staff keep clinical areas in good repair and maintain a safe and clean environment throughout the healthcare system. • Staff post notices in areas that are subject to photography or video recording.
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 low complexity (3) affiliated healthcare system reporting to VISN 22.[1]

Table B.1. Profile for Northern Arizona VA Health Care System (649) (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	$224,542,769	$313,454,727	$367,102,487
Number of: • Unique patients	28,146	28,594	28,789
• Outpatient visits	286,930	254,812	289,387
• Unique employees§	910	1,003	997
Type and number of operating beds: • Community living center	85	85	85
• Domiciliary	120	120	120
• Medicine (hospital)	15	15	15
Average daily census: • Community living center	57	39	20
• Domiciliary	104	64	55
• Medicine (hospital)	8	8	9

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

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

**October 1, 2018, through September 30, 2019.*
†October 1, 2019, through September 30, 2020.

‡*October 1, 2020, through September 30, 2021.*

§*Unique employees involved in direct medical care (cost center 8200).*

[1] VHA medical facilities are classified according to a complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." "Facility Complexity 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 26, 2023

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

Subj: Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System in Prescott

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

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 Northern Arizona VA Health Care System in Prescott, Arizona.
2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted action plans of the Northern Arizona VA Health Care System.
3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(Original signed by:)

Michael W. Fisher
VISN 22 Network Director

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: April 25, 2023

From: Director, Northern Arizona VA Health Care System (649/00)

Subj: Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System in Prescott

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 Northern Arizona VA Health Care System in Arizona. I concur with the findings and recommendations in the report.
2. Northern Arizona VA Health Care System remains committed to ensuring our Veterans receive exceptional health care.

(Original signed by:)

Steven J. Sample, MS, CHC, VHA-CM
Medical Center Director
Northern Arizona VA Health Care System

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