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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Butler VA Health Care System in Pennsylvania

CHIP Report | 22-00068-171 | August 10, 2023

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Figure 1. *Butler VA Medical Center of the Butler VA Health Care System in Pennsylvania.*

Source: https://www.va.gov/butler-health-care/locations/ (accessed October 26, 2022).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
TJC	The Joint Commission
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 within the Butler VA Health Care System, which includes the Butler VA Medical Center, Abie Abraham VA Clinic, and multiple outpatient clinics in Pennsylvania. 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 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)[1]

The OIG conducted an unannounced inspection of the Butler VA Health Care System during the week of June 27, 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.

[1] The OIG did not perform the mental health review at this healthcare system because it did not have an emergency department or urgent care center.

Inspection Results

The OIG noted opportunities for improvement and issued two recommendations to the Executive Director in the following areas of review: Quality, Safety, and Value and Environment of Care. These results are detailed throughout the report and summarized in appendix A on page 18.

Conclusion

The OIG issued two recommendations for improvement to the Executive 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 leaders to use recommendations as a road map to help improve operations and clinical care moving forward. 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 Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 20–21, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 1 and 2 closed.

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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 within the Butler 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 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)[5]

[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.

[5] The OIG did not perform the mental health review at this healthcare system because it did not have an emergency department or urgent care center.

Methodology

The Butler VA Health Care System includes the Butler VA Medical Center, Abie Abraham VA Clinic, and associated outpatient clinics in Pennsylvania. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from June 27, 2019, through July 1, 2022, the last day of the unannounced multiday evaluation.[6] 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.[7] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[6] The OIG's last comprehensive healthcare inspection of the Butler VA Health Care System occurred in June 2019. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in October 2020.

[7] 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.[8] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their vision and strategy, and "practice systems thinking and collaboration across boundaries."[9] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[10]

To assess this healthcare system's leadership and risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Executive Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director for Operations. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for approximately one month, although the Associate Director for Operations had served in the position since 2012. The Executive Director had been in the role for about three months but previously served in an acting capacity from June 17, 2019, through February 11, 2020, and again from July 27, 2021, until being permanently assigned in March 2022. The chief of staff position had been vacant for approximately two years, with five staff members serving in acting roles during that time. During the week of the inspection, the Acting Chief of Staff had been in the role for approximately one

[8] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[9] Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[10] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

month but had served in a leadership position in the system since August 2011. The Executive Director stated a permanent chief of staff had been selected and was scheduled to start in September 2022. The ADPCS position had been vacant for approximately 11 months, with a staff member serving in an acting capacity since July 2021. The Acting ADPCS had been in a leadership role in the system since June 2011. To help assess the executive leaders' engagement, the OIG interviewed the Executive Director, Acting Chief of Staff, Acting ADPCS, and acting Associate Director for Operations regarding their knowledge, involvement, and support of actions to improve or sustain performance.[11]

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $163,831,269 had increased nearly 17 percent compared to the FY 2020 budget of $140,390,748.[12] The Executive Director stated the current budget was adequate, and leaders were actively recruiting for staff to fill 100 positions at the time of the inspection. The acting Associate Director for Operations said leaders spent funds to pay employees overtime during the COVID-19 pandemic and for patient care in the community.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] 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.[14]

[11] During the week of the inspection, the Chief of Police was assigned as the acting Associate Director for Operations.

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

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

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

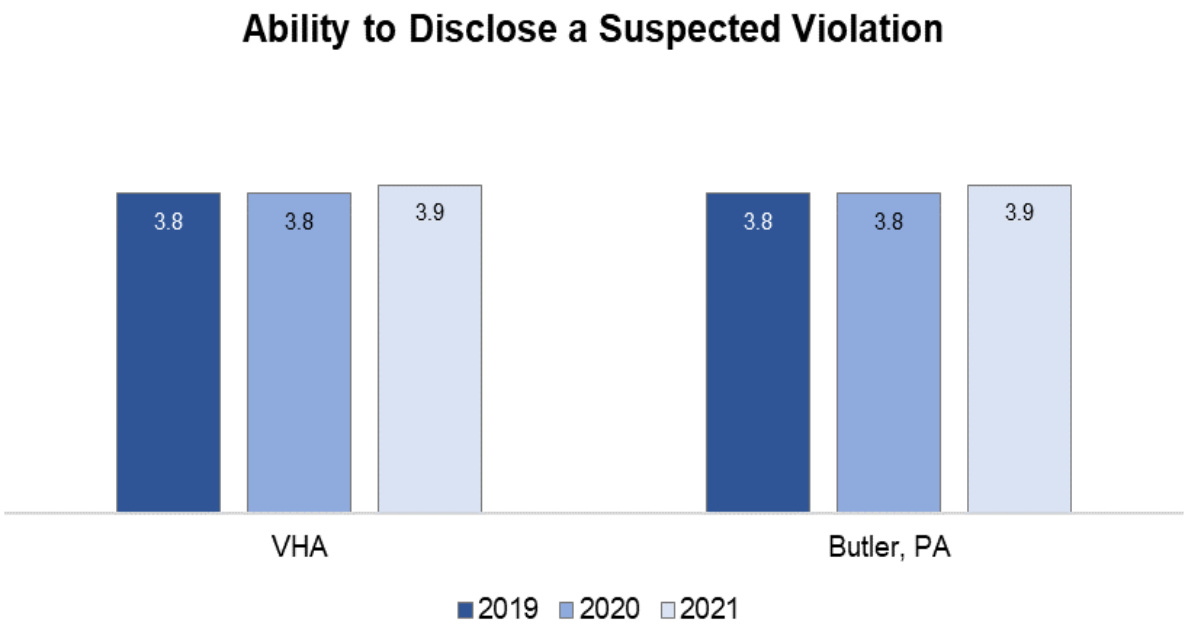

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed May 24, 2022).

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

Patient Experience

Veterans Health Administration (VHA) uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.[15]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[16] The OIG reviewed responses to two relevant survey questions that reflect patient experiences with the healthcare system from FYs 2018 through 2021.[17] Figures 3 and 4 provide survey results for VHA and the healthcare system over time.[18]

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

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

[17] The healthcare system does not have acute medical/surgical inpatient beds.

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

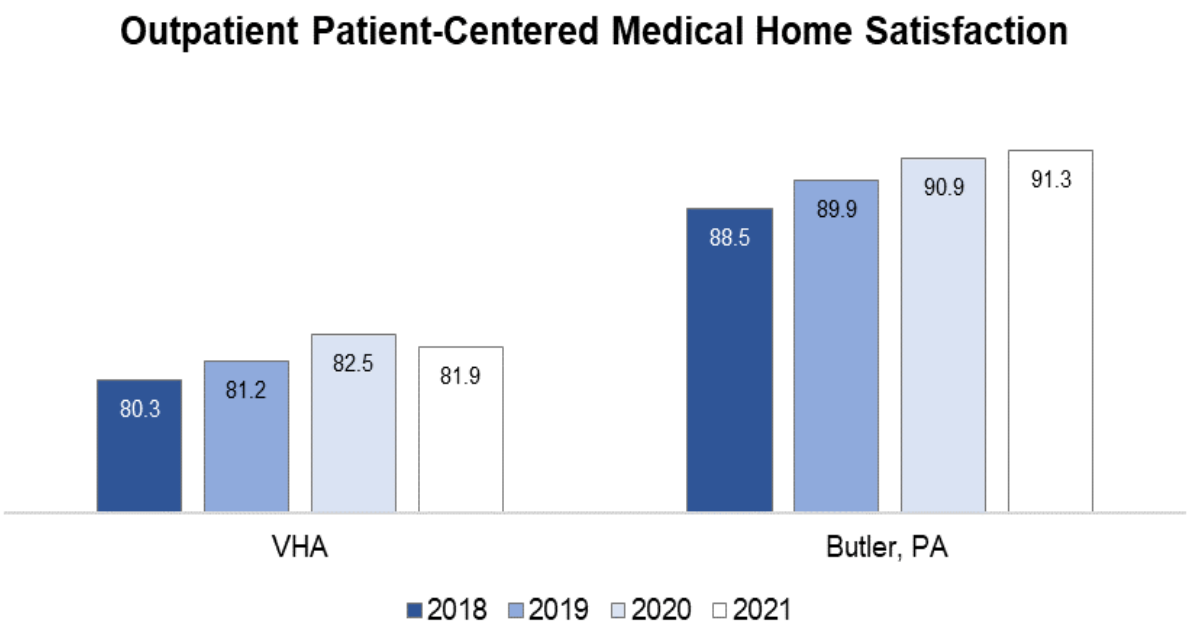

Figure 3. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

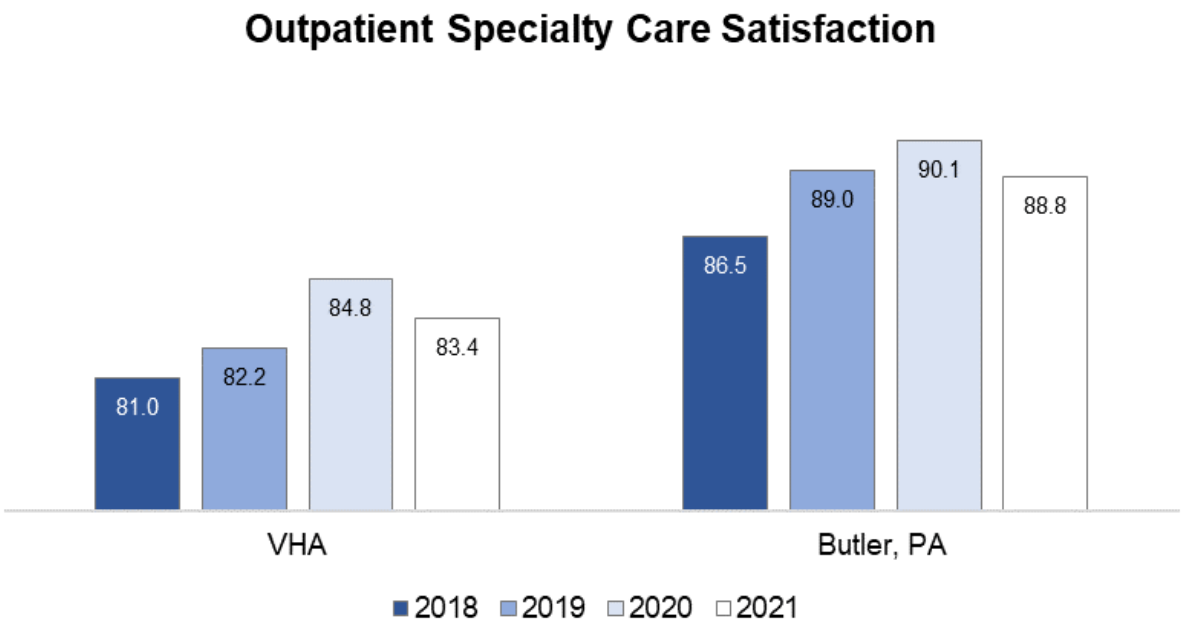

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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 a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[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

[19] Frankel et al., *A Framework for Safe, Reliable, and Effective Care, Institute for Healthcare Improvement*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[20] The Joint Commission (TJC), *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates TJC's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

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 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 (TJC'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 OIG requested sentinel events and institutional and large-scale disclosures that occurred from June 27, 2019, through June 27, 2022, and reviewed events reported by healthcare system staff. System leaders seemed knowledgeable about the adverse event reporting and institutional disclosure processes.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[22] VHA Directive 1004.08.

[23] TJC, *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.

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."[25] 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 TJC accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from TJC).[27]

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.[28] 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."[29] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[30]

Finally, the OIG assessed the healthcare system's culture of safety.[31] 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.

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

[26] 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.)

[27] VHA Directive 1100.16.

[28] 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.

[29] VHA Directive 1190.

[30] VHA Directive 1190.

[31] 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.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, one peer review designated as a final Level 3, patient safety reports, and other relevant information.[32]

Quality, Safety, and Value Findings and Recommendations

VHA uses the Joint Patient Safety Reporting system to capture real-time incident data throughout the VA healthcare system.[33] The patient safety manager is responsible for oversight of the adverse event reporting process, which includes initiating an individual root cause analysis for events with a potential or actual safety assessment code score of 3.[34] The OIG found that for adverse events with a safety assessment code score of 3 that occurred between June 1, 2021, and May 31, 2022, the Patient Safety Manager did not consistently initiate a root cause analysis, which may limit leaders' awareness of vulnerabilities that could lead to patient harm. The Acting Director for Quality and Patient Safety reported believing the events did not require a root cause analysis and discussing them with the Executive Director, who concurred.

Recommendation 1

1. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures the Patient Safety Manager initiates an individual root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.[35]

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

[33] VHA National Center for Patient Safety, *JPSR Business Rules and Guidebook,* July 2020; VHA National Center for Patient Safety, Guidebook for *JPSR Business Rules and Guidance,* November 2021.

[34] Adverse events and close calls are assigned a safety assessment code score based on the severity of the event and how often it occurs. The safety assessment code is a "ranked matrix score (3 = highest risk, 2 = intermediate risk, 1 = lowest risk)." 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.)

[35] 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: The Executive Director evaluated and did not determine any additional reasons for noncompliance. The Patient Safety Manager (PSM) implemented a process to ensure there is a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3. Of the 15 SAC [safety assessment code] 3/Potential SAC 3s, 11 JPSRs [Joint Patient Safety Reporting system entries] will be included in the Falls Aggregate RCA [root cause analysis] due December 1, 2023. Quality provided monthly audits on quarterly basis to Leadership committee to illustrate that all JPSRs with an actual or potential SAC of 3 have a completed RCA.

N [numerator]=Number of individual/aggregate RCA

D [denominator]=Number of all JPSRs with SAC 3 or Potential SAC 3

Compliance was reported to the leadership team through February 2023 and reported January through June 2023 through the Patient Safety Manager reports to the Medical Executive Committee until 90 percent or better compliance was sustained for six consecutive months.

Compliance of 90 percent sustained for six (6) consecutive months was achieved in June 2023.

July 2022=0/0 100%	January 2023=3/3 100%
August 2022=0/0 100%	February 2023=2/2 100%
September 2022=0/0 100%	March 2023=6/6 100%
October 2022=0/0 100%	April 2023=1/1 100%
November 2022=0/0 100%	May 2023=2/2 100%
December 2022=0/0 100%	June 2023=1/1 100%

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."[36] 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."[37]

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.[38] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[39]

VHA defines the Focused Professional Practice Evaluation as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[40] The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[41] 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.[42]

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.[43] 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

[36] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Handbook 1100.19.

[42] VHA Handbook 1100.19.

[43] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[44]

The OIG interviewed key managers and selected and reviewed the privileging folders of 11 medical staff members who had a Focused Professional Practice Evaluation or were reprivileged in the previous 12 months.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[44] 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.

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.[45] 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.[46]

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.[47] 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.[48]

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

[45] 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.)

[46] 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.

[47] 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.

[48] 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.

- Abie Abraham VA Clinic
  - Primary care clinics (general primary care and women's health)
- Butler VA Medical Center
  - Community living center (Halls of Honor and Village of Valor areas)

Environment of Care Findings and Recommendations

VHA requires staff to follow TJC requirements for monitoring environmental conditions to ensure a clean, safe environment.[49] During environment of care inspections at the Abie Abraham VA Clinic, the OIG found two ice and water machines, one located in the primary care clinic and one near the women's health clinic, had dirty water tubes at the dispensing end. An unsafe and unclean clinical environment could result in illness among patients, visitors, and staff. The Health Care Center Program Manager stated the Abie Abraham VA Clinic building was a leased property and non-VA staff did the cleaning but acknowledged follow-up was needed.

Recommendation 2

2. The Executive Director determines any additional reasons for noncompliance and ensures leaders maintain a clean and safe environment.[50]

[49] VHA Directive 1608; VHA Directive 1100.16; TJC, *Standards Manual*, EC.02.06.01, December 2019.

[50] 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: The Executive Director evaluated and did not determine any additional reasons for noncompliance. The Butler Health Care Center was following manufacturer recommendations of cleaning ice machine to include water tubes at the dispensing end annually. To ensure a clean and safe environment, the cleaning of ice machines to include water tubes was changed to monthly.

N [numerator]=Number of ice machines cleaned

D [denominator]=Number of ice machines in the Health Care Center (HCC)

Compliance was reported to the Leadership Committee quarterly until 90% or better compliance was sustained for six consecutive months.

Compliance of 90 percent sustained for six (6) consecutive months was achieved in November 2022.

June=25/25 100%

July=25/25 100%

August=25/25 100%

September=25/25 100%

October=25/25 100%

November=25/25 100%

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 four clinical and administrative areas and provided two recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines two OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Executive Director. The intent is for this leader 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	• The Patient Safety Manager initiates an individual root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.
Medical Staff Privileging	• None
Environment of Care	• Leaders maintain a clean and safe environment.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) healthcare system reporting to VISN 4.[1]

Table B.1. Profile for Butler VA Health Care System (529)
(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	$111,151,547	$140,390,748	$163,831,269
Number of:			
• Unique patients	26,738	22,168	22,974
• Outpatient visits	214,541	192,299	214,110
• Unique employees§	525	579	565
Type and number of operating beds:			
• Community living center	97	97	97
• Domiciliary	56	56	56
• Mental health	10	10	10
Average daily census:			
• Community living center	58	46	42
• Domiciliary	52	35	26
• Mental health	9	8	4

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." "VHA Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES).

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 11, 2023

From: Director, VISN 4: VA Healthcare (10N4)

Subj: Comprehensive Healthcare Inspection of the Butler VA Health Care System in Pennsylvania

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

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

1. Thank you for the opportunity to review the draft report, Comprehensive Healthcare Inspection of the Butler VA Health Care System in Pennsylvania.
2. I have reviewed the recommendations in the OIG draft report. I concur with the recommendations and action plans submitted by the Butler VA Health Care System.

(Original signed by:)

Timothy W. Liezert
Network Director, VISN 4

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: July 11, 2023

From: Director, Butler VA Health Care System (529)

Subj: Comprehensive Healthcare Inspection of the Butler VA Health Care System in Pennsylvania

To: Director, VISN 4: VA Healthcare (10N4)

1. I have reviewed the VA OIG's draft report of the CHIP review conducted at the VA Butler Health Care Center of Butler, Pennsylvania. I concur with the OIG's recommendations.
2. I am submitting my plan and completed monitors to show compliance with the recommendations to include request for closure of our two recommendations.
3. I appreciate the OIG's partnership in our continuous improvement efforts.

(Original signed by:)

Sharon Coyle, MSN, RN, MBA
Executive Director, Butler VA Health Care System

OIG Contact and Staff Acknowledgments

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