US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Sierra Nevada Health Care System in Reno

CHIP Report | 22-00230-190 | September 14, 2023

BE A

VOICE FOR VETERANS

REPORT WRONGDOING

va.gov/oig/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more! Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

QUALITY STANDARDS

The Office of Inspector General (OIG) has released this management advisory memorandum to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation, excluding follow-up.

Figure 1. *Ioannis A. Lougaris VA Medical Center of the VA Sierra Nevada Health Care System in Reno.*

Source: https://www.va.gov/sierra-nevada-health-care/locations/ (accessed April 22, 2022).

Abbreviations

ADPCS/NE	Associate Director, Patient Care Services/Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Sierra Nevada Health Care System in Reno, which includes the Ioannis A. Lougaris VA Medical Center and multiple outpatient clinics in California and Nevada. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

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

The OIG conducted an unannounced inspection of the VA Sierra Nevada Health Care System during the weeks of April 25 and May 2, 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 Director; Chief of Staff; and Associate Director, Patient Care Services/Nurse Executive in the following areas of review: Quality, Safety, and Value; Environment of Care; and Mental Health. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 24.

Conclusion

The OIG issued six recommendations for improvement to the Director; Chief of Staff; and Associate Director, Patient Care Services/Nurse Executive. 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 interim 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 26–27, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 3 and 4 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

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

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

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

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

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

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

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

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

Methodology

The VA Sierra Nevada Health Care System includes the Ioannis A. Lougaris VA Medical Center and associated outpatient clinics in California and Nevada. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from January 22, 2018, through May 4, 2022, the last day of the unannounced multiday evaluation.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

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

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

[5] The OIG's last comprehensive healthcare inspection of the VA Sierra Nevada Health Care System occurred in January 2018. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in March 2019.

[6] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

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

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

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director; Deputy Director; Associate Director; Chief of Staff; and Associate Director, Patient Care Services/Nurse Executive (ADPCS/NE). The Chief of Staff and ADPCS/NE 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 more than five months, except for the ADPCS/NE, who was assigned on April 10, 2022. To help assess the executive leaders' engagement, the OIG interviewed the Director, Deputy Director, Chief of Staff, and ADPCS/NE regarding their knowledge, involvement, and support of actions to improve or sustain performance.

[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 et al., *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.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $440,571,236 had increased by approximately 11 percent compared to the previous year's budget of $395,505,712.[10] The Director reported the medical care budget was adequate, and the additional funds helped in hiring employees, which was made difficult by the area's high cost of living. The Director discussed a need for VA to increase salaries for hard-to-fill positions and provided an example of a physician assistant candidate who was offered a position but declined due to the comparatively low salary. The Director also said leaders used the budget increase to purchase equipment and fund construction projects. The Director added that the size of the main facility is not sufficient to accommodate its patients and services.

The Deputy Director reported the budget increase came from grants and special purpose funds. In addition, the Deputy Director shared that leaders hired about 180 staff, mostly clinical, during the COVID-19 pandemic and spent a large amount of the budget converting new intensive care unit rooms to negative pressure rooms for COVID-19 patients.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] 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 to 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal (see figure 2).[12]

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

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

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

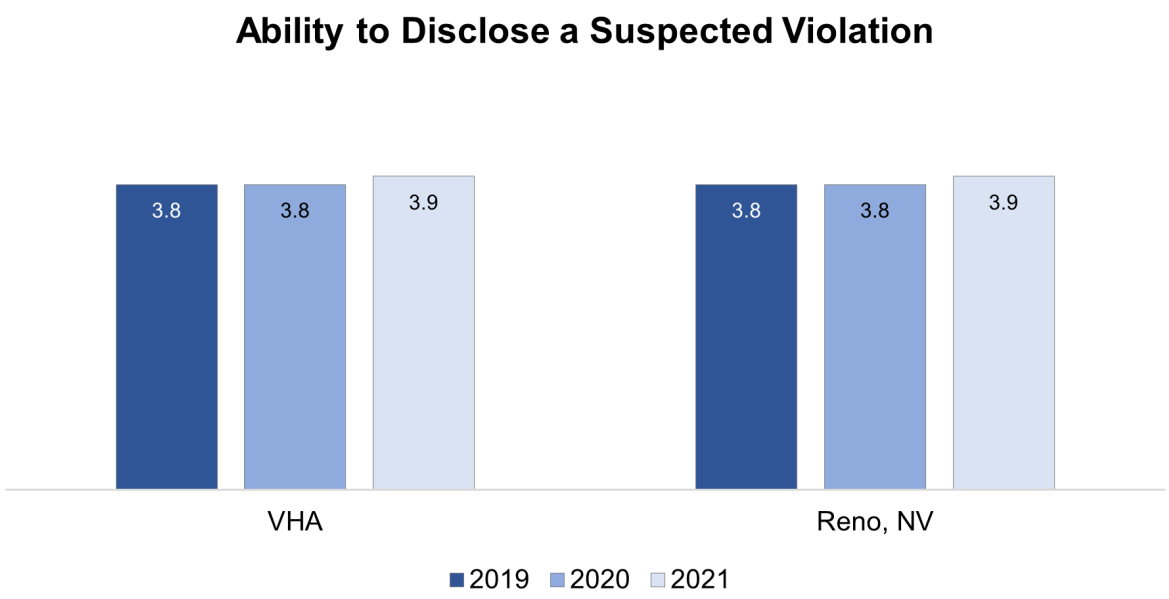

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed March 1, 2022).

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

Patient Experience

The 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.[13]

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

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

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

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

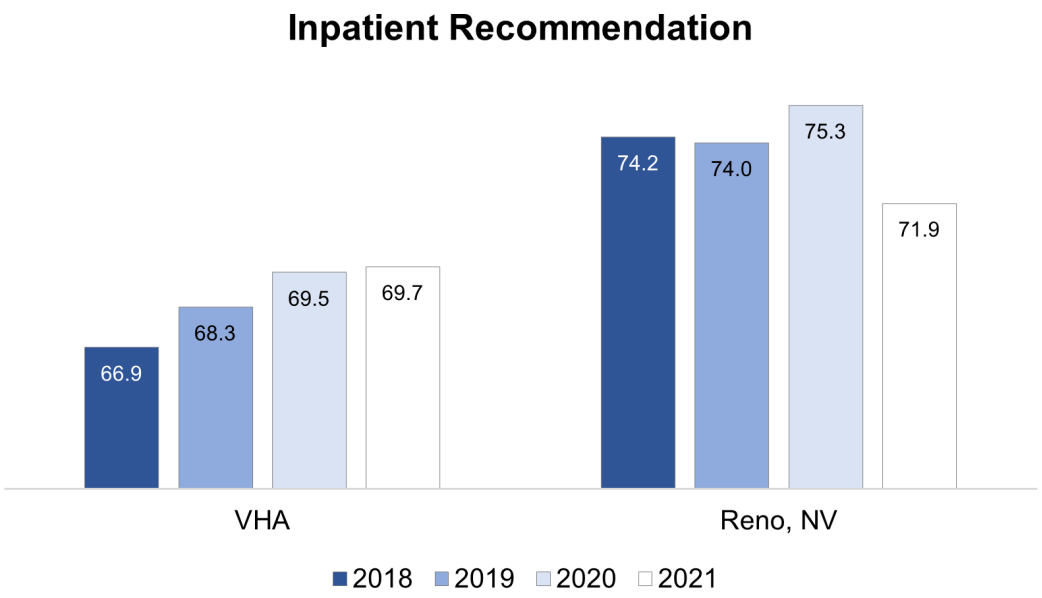

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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

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

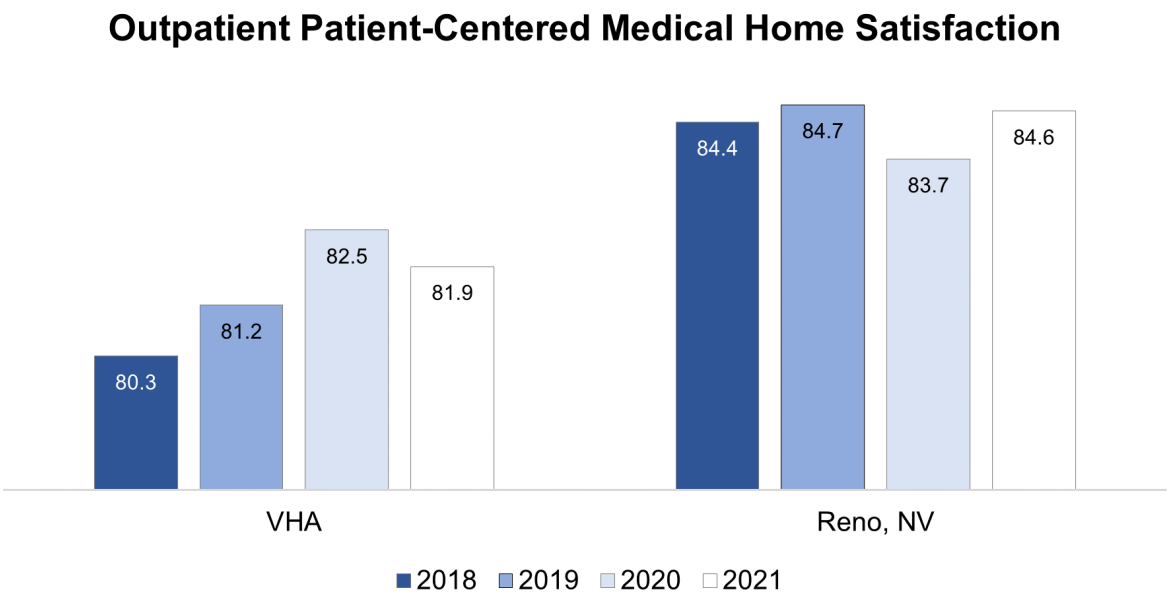

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

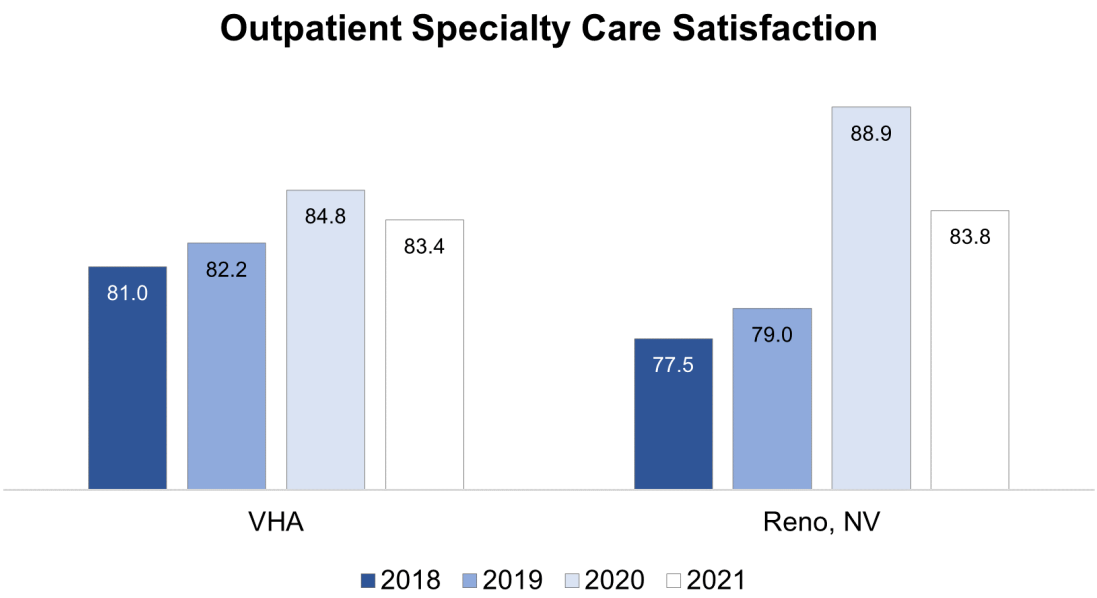

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.[16] "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)."[17] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and

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

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

recourse."[18] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[19] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[20] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[21]

During individual interviews, the OIG asked leaders about the system's process for sentinel events and institutional disclosures. The Director reported receiving a daily report of adverse events that is discussed with quality management staff and a spreadsheet containing sentinel events and institutional disclosures. In addition, the Director stated that the Chief of Staff reports on institutional disclosures. The Chief of Staff explained that once leaders decide to conduct an institutional disclosure, they refer the event to the Risk Manager, who is responsible for initiating the process.

The OIG reviewed the sentinel events and institutional disclosures reported by healthcare system staff that occurred since the OIG comprehensive healthcare inspection in January 2018.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[19] VHA Directive 1004.08.

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

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

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

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.[25] 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."[26] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[27]

Finally, the OIG assessed the healthcare system's culture of safety.[28] 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.

---

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

[23] 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.)

[24] VHA Directive 1100.16.

[25] 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.

[26] VHA Directive 1190.

[27] VHA Directive 1190.

[28] 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 20, 2021, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

Quality, Safety, and Value Findings and Recommendations

VHA requires the initial peer reviewer to assign "one or more of the nine aspects of care" for a Level 3 peer review, which "must be annotated to support the level of care assigned."[29] The OIG found that one of two final Level 3 peer reviews lacked evidence the reviewer documented at least one of the nine aspects of care. Failure to use any of the aspects of care may negatively affect the reviewers' ability to determine if the practitioner provided appropriate care. The Quality Review Nurse reported that the Peer Review Committee usually documents aspects of care in the meeting minutes but acknowledged a lack of oversight as a reason for noncompliance.

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures peer reviewers consistently document at least one of the nine aspects of care for Level 3 peer reviews.

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response: The Chief of Staff considered the reasons for noncompliance and did not determine additional reasons for noncompliance. The Quality Review Nurse will review all initial peer review forms monthly for completeness which includes documentation of at least one aspect of care for all Level 3 cases. The peer review forms without at least one aspect of care selected will be returned to the initial peer reviewer to complete. The numerator equals final Level 3 peer review cases each month with at least one aspect of care selected. The denominator equals the total number of completed peer review cases assigned a final Level 3 each month. The Quality Review Nurse will monitor Level 3 peer review data monthly for completeness until 90 percent or higher compliance is achieved for six consecutive months to demonstrate sustainment. The Quality Review Nurse will report Level 3 peer review compliance to the Medical Executive Committee quarterly.

VHA requires the Peer Review Committee to complete a final review of peer review cases and recommend "non-punitive, non-disciplinary actions to improve the quality of health care

[29] A Level 3 peer review "is the level at which most experienced and competent clinicians would have managed the case differently." Aspects of care are clinical actions used to determine the level of care provided. VHA has identified nine aspects of care: "(1) Choice and/or timeliness in ordering of diagnostic tests. (2) Addressing abnormal results of diagnostic tests. (3) Timeliness of treatment initiation and/or appropriate treatment choice. (4) Performance of a procedure or treatment. (5) Timeliness and/or appropriateness of diagnosis. (6) Recognition and communication of critical clues to patient's clinical condition. (7) Timely initiation of appropriate actions during periods of clinical deterioration. (8) Health record documentation. (9) Supervision of health profession trainees." VHA Directive 1190.

delivered."[30] The OIG found that one of two final Level 3 peer reviews lacked evidence the committee recommended improvement actions. Failure to recommend actions likely prevented improvements in the practitioners' patient care practices. The Quality Review Nurse explained that the Peer Review Committee's meeting minute format was not user friendly and contributed to the noncompliance.

Recommendation 2

2. The Chief of Staff evaluates reasons for noncompliance and ensures the Peer Review Committee recommends improvement actions for all final Level 3 peer reviews.

Healthcare system concurred.

Target date for completion: September 30, 2023

Healthcare system response: The Chief of Staff did not identify additional reasons for noncompliance when developing this action plan. The Quality Review Nurse revised the Peer Review Committee minutes template to include a larger section for discussion and recommendations for individual improvement actions and follow up in June 2022. The template was implemented on July 1, 2022. The Chief of Quality and Patient Safety will audit Peer Review Committee minutes monthly to ensure all final peer reviews with a Level 3 rating have documented individual recommended improvement actions. The numerator is the number of Level 3 cases with documented recommended improvement actions in Peer Review Committee minutes. The denominator is the number of all final Level 3 cases discussed each month in the Peer Review Committee. The Quality Review Nurse will monitor compliance until at least 90 percent is achieved for six consecutive months to demonstrate sustainment. The Quality Review Nurse will report compliance quarterly to the Medical Executive Committee.

[30] VHA Directive 1190.

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."[31] 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."[32]

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.[33] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[34]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges. 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.[35]

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.[36] 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

[31] 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.)

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[37]

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

- One solo practitioner who underwent clinical privileging[38]
- Nine LIPs who had a Focused Professional Practice Evaluation
- Twenty LIPs who were reprivileged

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[37] 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.

[38] 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.)

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.[39] 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.[40]

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.[41] 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.[42]

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:

- Community living center

[39] 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.)

[40] 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.

[41] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," November 17, 2021, accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

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

- Emergency Department
- Intensive care unit
- Medical/surgical inpatient unit (B5)
- Mental health inpatient unit
- Pain clinic
- Women's health clinic

Environment of Care Findings and Recommendations

VHA requires staff at facilities with mental health inpatient units to perform systematic environmental assessments using the Mental Health Environment of Care Checklist to identify and address environmental risks for patients under treatment.[43] The Mental Health Environment of Care Checklist criteria state that testing of panic alarms "should be done on a periodic basis" and "testing should be recorded in a log and include response-time by police."[44] The OIG reviewed the alarm testing log from January through March 2022 and did not find evidence police documented their response times. Failure to monitor police response times may put patients, visitors, and staff at risk in the event of an emergency. The Chief of Police did not provide a reason for noncompliance.

Recommendation 3

3. The Director determines the reasons for noncompliance and ensures police document their response times to panic alarm testing in the mental health inpatient unit.[45]

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

[44] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," September 30, 2020.

[45] 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 Director reviewed the recommendation and did not identify any reasons for noncompliance. The VA Police staff conducted monthly testing of Inpatient Mental Health unit panic alarms from June 2022 through February 2023 and documented the police response time for each test. The Chief of Police will monitor the monthly alarm tests and ensure the police response time is documented until 90 percent compliance is achieved then monitor for six consecutive months to demonstrate sustainment. Testing of Inpatient Mental Health unit panic alarms will continue to be conducted and documented at least quarterly. The Chief of Police or designee will report panic alarm testing and corresponding police response time quarterly to the Environment of Care Council.

VHA requires the facility chief of staff or associate director, patient care services to ensure "video or audio monitoring equipment installed for patient safety purposes is only accessed and viewed by VA health care providers, who are responsible for ensuring the safe delivery of care and authorized to take action based on the monitoring accessed" and "equipment is used to monitor (rather than record) the patient."[46] The OIG found that although cameras throughout the mental health area were there to monitor patient safety, the cameras were also recording. When cameras record, the information may be viewed by unauthorized personnel and violate patients' right to consent to video recording. The Nurse Manager, Extended Care and Mental Health Nursing stated that staff monitor the cameras for patient safety. The Chief of Police and the Physical Security Specialist reported that facility management service staff oversaw the cameras until the police took over in December 2021. The Chief of Police further explained that the cameras' video recording function would be disabled effective May 5, 2022.

Recommendation 4

4. The Chief of Staff or Associate Director, Patient Care Services/Nurse Executive evaluates and determines any additional reasons for noncompliance and ensures cameras used for patient safety monitoring do not record.[47]

[46] VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021.

[47] 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 Associate Director, Patient Care Services/Nurse Executive did not identify any additional reasons for noncompliance. In May 2022, the security systems project manager disabled the recording function of the network video recorder on the Inpatient Mental Health unit and turned on the live view only function which was observed by the VA Physical Security Specialist.

Mental Health Environment of Care Checklist criteria state that "items projecting from the wall, even if otherwise considered a safety item," should be designed so that they cannot be used for self-harm.[48] In the mental health inpatient unit, the OIG found that grab rails in the inspected patient bathrooms had sharp edges, which increases the risk of patients' self-harm. The Chief, Maintenance and Operations said the metal plates on the grab rails were not properly rounded on installation. Although the Chief, Maintenance and Operations reported correcting the issue during the site visit, on reassessment, the OIG noticed that some areas on the grab rails still had sharp edges.

Recommendation 5

5. The Chief of Staff and Associate Director, Patient Care Services/Nurse Executive evaluate and determine any additional reasons for noncompliance and ensure staff minimize risks of patients' self-harm in the mental health inpatient unit.

[48] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist."

Healthcare system concurred.

Target date for completion: December 30, 2023.

Healthcare system response: The Associate Director, Patient Care Services/Nurse Executive did not determine any additional reasons for noncompliance. The Chief of Mental Health Services will ensure all restroom grab rails' sharp edges are smoothed and then a permanent sealant applied in the Inpatient Mental Health unit patient care rooms by December 30, 2023. All safety issues identified during the Mental Health Environment of Care Checklist inspections will be addressed and status of corrective actions reported to the Interdisciplinary Safety Inspection Committee which meets at least four times a year. The numerator is the number of Inpatient Mental Health unit patient care bathroom grab rails that have been smoothed with permanent sealant applied. The denominator equals the total number of bathroom grab rails in the Inpatient Mental Health unit patient care rooms. The Chief of Mental Health Services or designee will report compliance data to the Environment of Care Council quarterly until 100 percent compliance is met.

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."[49] 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."[50]

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.[51] 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."[52] 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.

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

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

[51] 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.)

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

Mental Health Findings and Recommendations

VHA requires staff to attempt at least weekly follow-up until mental health care is established for patients "determined to be at intermediate or high-acute or chronic risk of suicide via the VA Comprehensive Suicide Risk Evaluation (CSRE) and are deemed to be safe to discharge to home" from the emergency department.[53] The OIG found that electronic health records for three of nine applicable patients lacked evidence staff followed up within seven days of discharge from the Emergency Department. Lack of follow-up may lead to missed opportunities for staff to provide support, continue risk mitigation, ensure smooth care transition, and monitor continuity of care. The acting Chief, Mental Health Service attributed noncompliance to the lack of a standardized weekly follow-up process, outpatient mental health providers being unaware of the requirement, delays in mental health consult processing, and difficulty reaching patients to schedule follow-up appointments.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures staff attempt weekly follow-up until mental health care is established for patients determined as intermediate or high-acute or chronic risk of suicide on the Comprehensive Suicide Risk Evaluation who are discharged home from the Emergency Department.

[53] 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." 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."

Healthcare system concurred.

Target date for completion: October 1, 2023.

Healthcare system response: The Chief of Staff found no additional reasons for noncompliance. The Suicide Prevention Supervisor and team reviews the Emergency Department dashboard Safety Planning data daily to ensure patients receive timely follow up. Suicide Prevention Case Managers will attempt phone contact with patients discharged daily from the Emergency Department that had an intermediate or higher acute or chronic risk for suicide on the Comprehensive Suicide Risk Evaluation. The Suicide Prevention Case Managers will initiate patient-phone contact within seven days of discharge and weekly thereafter until the patient is either engaged in mental health care, declined further outreach, or had at least four consecutive unsuccessful weekly phone attempts including a mailed outreach letter. The numerator is the number of patients discharged from the Emergency Department at elevated risk of suicide that had a follow up phone contact within seven days, declined further outreach, or have documented evidence of at least four consecutive unsuccessful weekly phone attempts including a mailed outreach letter. The denominator is the number of patients at elevated risk of suicide discharged from the Emergency Department monthly. The Suicide Prevention Supervisor will conduct monthly audits until at least 90 percent or higher compliance is achieved and monitor for six consecutive months to demonstrate sustainment. The Suicide Prevention Supervisor or designee will report compliance data quarterly to the Quality and Patient Safety Council.

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 and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and ADPCS/NE. 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	• Peer reviewers consistently document at least one of the nine aspects of care for Level 3 peer reviews. • The Peer Review Committee recommends improvement actions for all final Level 3 peer reviews.
Medical Staff Privileging	• None
Environment of Care	• Police document their response times to panic alarm testing in the mental health inpatient unit. • Cameras used for patient safety monitoring do not record. • Staff minimize risks of patients' self-harm in the mental health inpatient unit.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Staff attempt weekly follow-up until mental health care is established for patients determined as intermediate or high-acute or chronic risk of suicide on the Comprehensive Suicide Risk Evaluation who are discharged home from the Emergency Department.

Appendix B: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated healthcare system reporting to VISN 21.[1]

Table B.1. Profile for VA Sierra Nevada Health Care System (654) (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	$333,767,239	$395,505,712	$440,571,236
Number of:			
• Unique patients	33,305	29,661	30,846
• Outpatient visits	460,823	365,313	439,899
• Unique employees§	1,372	1,461	1,538
Type and number of operating beds:			
• Community living center	60	60	60
• Medicine	40	40	40
• Mental health	14	19	19
• Surgery	10	10	10
Average daily census:			
• Community living center	52	36	28
• Medicine	35	31	35
• Mental health	13	12	10
• Surgery	6	4	5

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 "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." "VHA 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: August 16, 2023

From: Director, VA Sierra Pacific Network (10N21)

Subj: Comprehensive Healthcare Inspection of the VA Sierra Nevada Health Care System in Reno

To: Director, Office of Healthcare Inspections (54CH06)

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

1. Thank you for the opportunity to respond to the draft report, Comprehensive Healthcare Inspection of the VA Sierra Nevada Health Care System in Reno.
2. I have reviewed the findings and recommendations in the OIG draft report. I concur with the submitted action plans.

(Original signed by:)

Ada Clark, FACHE, MPH
Interim Network Director
VA Sierra Pacific Network (VISN 21)

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: August 16, 2023

From: Director, VA Sierra Nevada Health Care System (654)

Subj: Comprehensive Healthcare Inspection of the VA Sierra Nevada Health Care System in Reno

To: Director, VA Sierra Pacific Network (10N21)

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

(Original signed by:)

Kevin P. Amick, MBA, MHRM
Executive Director (00)
VA Sierra Nevada Health Care System

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Rachel Agbi, DBA, MSN Patricia Calvin, MBA, RN Rowena Jumamoy, MSN, RN Judy Montano, MS
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Christopher D. Hoffman, LCSW, MBA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 21: VA Sierra Pacific Network
Director, VA Sierra Nevada Health Care System (654)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
  California: Dianne Feinstein, Alex Padilla
  Nevada: Catherine Cortez Masto, Jacky Rosen
US House of Representatives
  California: Kevin Kiley, Doug LaMalfa
  Nevada: Mark Amodei, Steven Horsford, Susie Lee, Dina Titus

OIG reports are available at www.va.gov/oig.