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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

CHIP Report | 22-00237-05 | October 25, 2023

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Figure 1. *Fayetteville VA Medical Center of the Veterans Health Care System of the Ozarks in Arkansas.*

Source: https://www.va.gov/fayetteville-arkansas-health-care/locations/.

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
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 Veterans Health Care System of the Ozarks, which includes the Fayetteville VA Medical Center and multiple outpatient clinics in Arkansas, Missouri, and Oklahoma. 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 Veterans Health Care System of the Ozarks during the weeks of August 15, 22, and 29, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement and issued five recommendations to the Director, Chief of Staff, and Associate Director for Patient Care Services in the following areas of review: Leadership and Organizational Risks, Medical Staff Privileging, 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 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 System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 26-27, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendation 4 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 Veterans Health Care System of the Ozarks 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 Veterans Health Care System of the Ozarks includes the Fayetteville VA Medical Center and associated outpatient clinics in Arkansas, Missouri, and Oklahoma. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from March 3, 2018, through August 31, 2022, the last day of the unannounced multiday evaluation.[5]

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

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

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

[5] The OIG's last comprehensive healthcare inspection of the Veterans Health Care System of the Ozarks concluded in March 2018.

[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, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, many of the executive leaders had worked together for more than one year. The Chief of Staff was assigned in December 2021. Four acting directors had been temporarily reassigned to the director position since May 4, 2021.[10] The fourth was assigned on May 18, 2022. The Assistant Human Resources Officer/Senior Strategic Business Partner reported that VHA Central Office staff were recruiting to fill the director position. To help assess

[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.

[10] The previous Director was reassigned to the VISN on May 4, 2021, and resigned from the VISN on March 28, 2022.

the executive leaders' engagement, the OIG interviewed the acting Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $625,166,736 had increased by approximately 23 percent compared to the previous year's budget of $508,832,608.[11] The acting Director reported that the medical care budget was adequate to meet operational needs and the additional funds allowed leaders to hire more clinical staff (averaging four to five every two weeks), enabling them to increase to 1,900 full-time equivalent employees. The acting Director also stated that leaders currently spent $370,000 a day on care in the community.[12]

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.

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

[12] VA pays for care by community providers in certain circumstances. "Community Care: Veteran Care Overview," Department of Veterans Affairs, accessed August 28, 2023, https://www.va.gov/COMMUNITYCARE/programs/veterans/index.asp.

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

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]

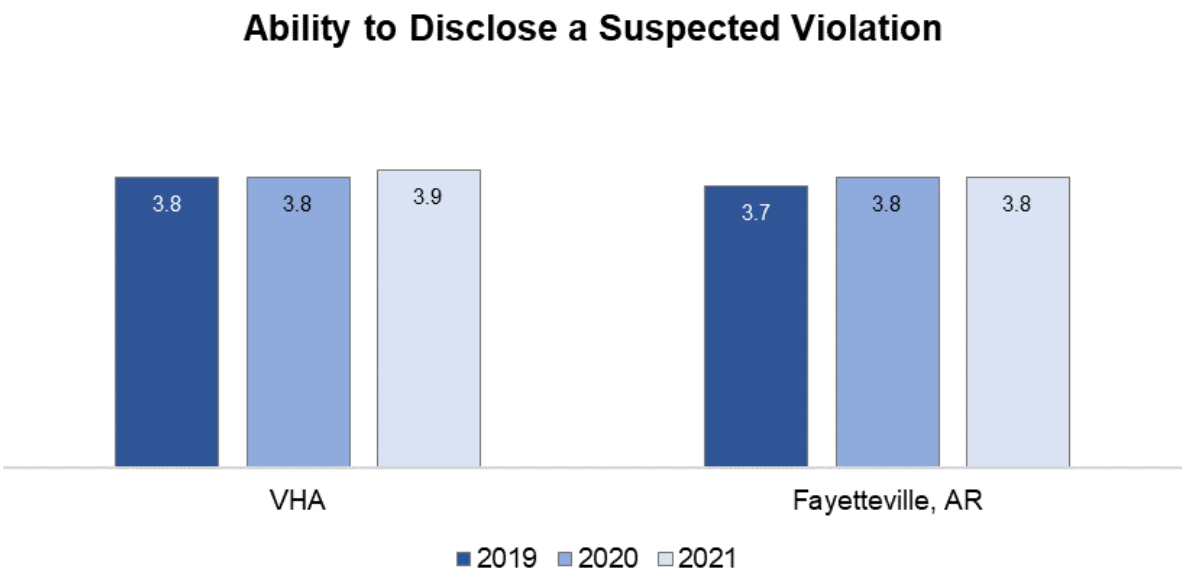

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed July 12, 2022).

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

[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).

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 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.[17]

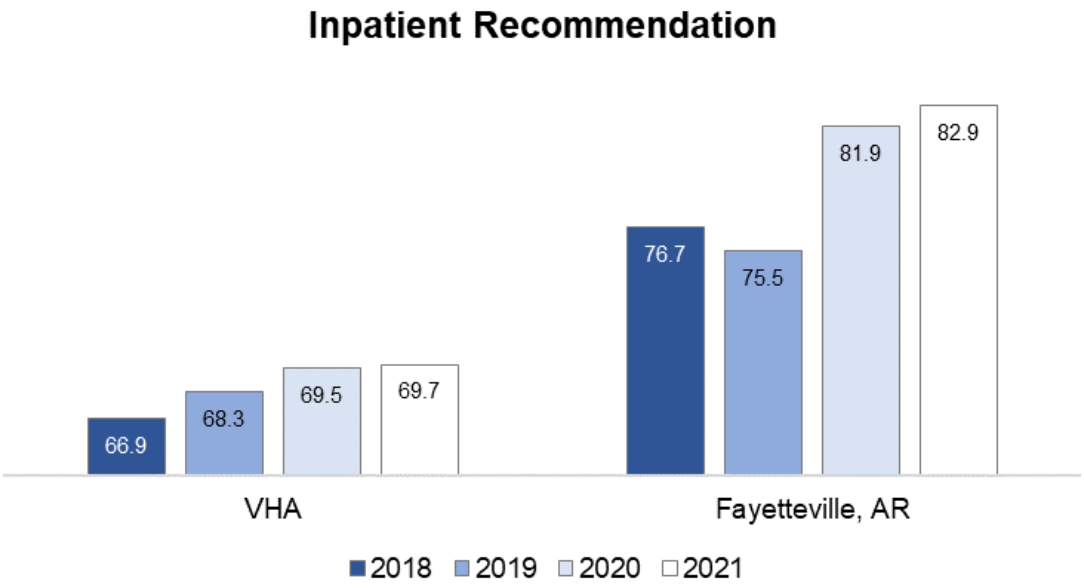

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

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

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

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

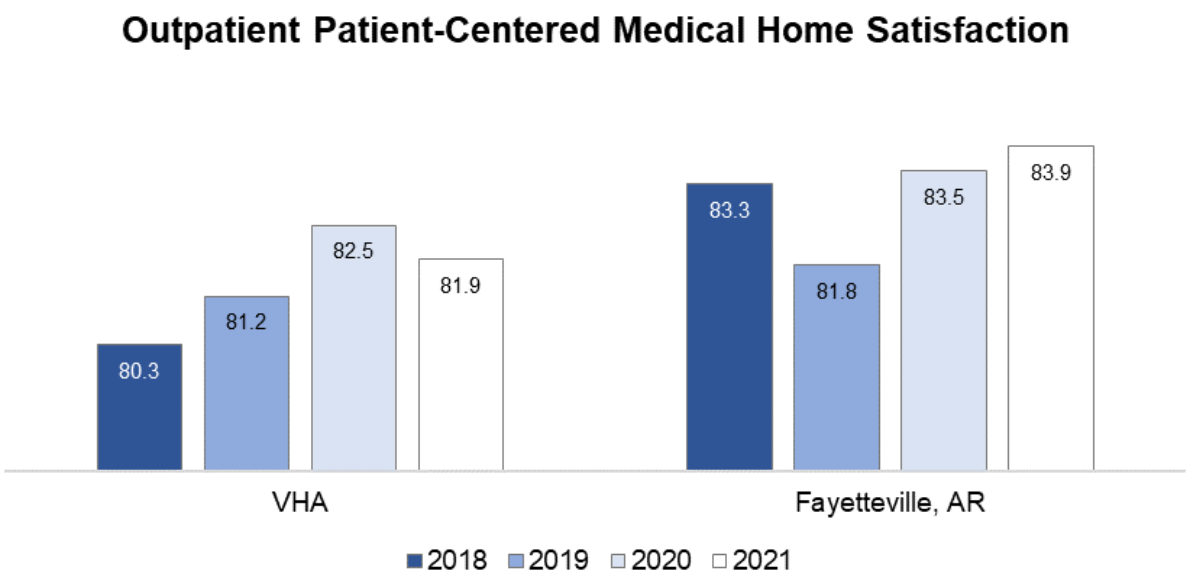

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

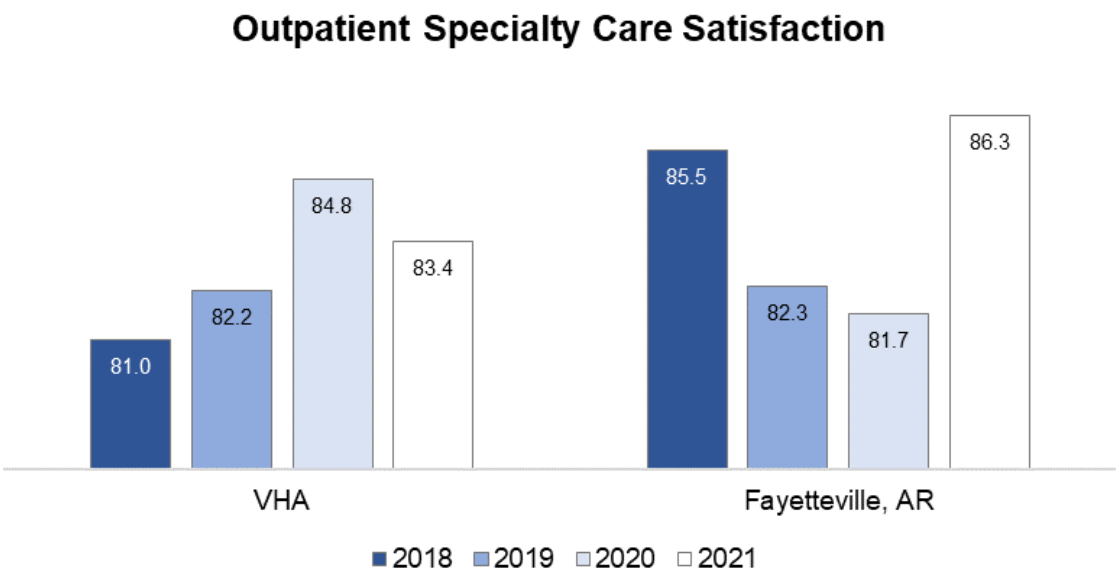

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.[18] "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)."[19] 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

[18] 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/.

[19] 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."[20] 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."[21] 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.[22] 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.[23]

The Patient Safety Manager and risk managers said they discussed patient safety events in morning leadership meetings. Additionally, the acting Director reported meeting regularly with the acting Chief of Quality, Safety and Value as well as being notified of safety events by the Chief of Staff, ADPCS, and Patient Safety Manager. The acting Director and Patient Safety Manager also stated that newly hired staff learned about patient safety event documentation during New Employee Orientation. Lastly, the acting Director explained that to encourage reporting, leaders recognized staff at town hall meetings for identifying patient safety events.

The acting Director stated the Chief of Staff made the final determination on providing institutional disclosures. The risk managers said that after they review electronic health records, they notify the Chief of Staff about the need for institutional disclosures.

Leadership and Organizational Risks Findings and Recommendations

VHA requires leaders to conduct institutional disclosures for adverse events that "resulted in or is reasonably expected to result in death or serious injury…including, for example sentinel events as defined by The Joint Commission."[24] The OIG requested adverse patient safety events that occurred from March 3, 2018 (the prior OIG CHIP site visit), through August 14, 2022, and reviewed the information staff provided. The OIG found that leaders did not consistently conduct institutional disclosures for sentinel events that may have contributed to the patients' deaths. Failure to perform an institutional disclosure can reduce patients' trust in the organization. The

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

[21] VHA Directive 1004.08.

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

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

[24] VHA Directive 1004.08.

Chief of Staff attributed the deficiency to turnover among leadership team members and quality, safety, and value staff. Further, the Chief of Staff and acting Chief of Quality, Safety and Value stated there was a lack of formal communication between quality, safety, and value staff and executive leaders.

Recommendation 1

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

Healthcare system concurred.

Target date for completion: March 31, 2024

Healthcare system response: The Director reviewed the recommendation and determined no additional reasons for noncompliance. The Patient Safety Managers will present all sentinel events to the Risk Managers at a monthly meeting where sentinel events are cross-checked with Joint Patient Safety Reports to validate all sentinel events were discussed and to identify possible institutional disclosures. The Risk Managers will then meet monthly with the Chief of Staff to present all sentinel events and discuss when an institutional disclosure is appropriate. Formal monthly meeting minutes will be maintained by the Risk Managers and reviewed and signed by the Chief of Staff. The Risk Managers will report the number of sentinel events requiring institutional disclosure (denominator), the number of institutional disclosures conducted (numerator), and the compliance percentage monthly to the Medical Executive Council, which is chaired by the Chief of Staff. The Chief of Staff will report this same data to the Executive Leadership Board, which is chaired by the Director. The Risk Managers will monitor and report until a minimum of 90 percent compliance is maintained for six consecutive months.

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 that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[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.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

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[25] Department of Veterans Affairs, *Veterans 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.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[32] 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."[33]

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.[34] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[35]

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.[36]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[37] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the chief of staff. VHA also requires facilities to have credentialing

[32] 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.)

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Directive 1100.20.

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

The OIG interviewed key managers and selected and reviewed the privileging folders of 30 medical staff members, including solo or few LIPs.[39]

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to incorporate service-specific criteria in Ongoing Professional Practice Evaluations.[40] The OIG found that one solo LIP's Ongoing Professional Practice Evaluations lacked service-specific criteria.[41] This resulted in leaders deciding to continue the LIP's privileges based on incomplete data, which could have adversely affected the quality of care and patient safety. The Chief of Staff, who assumed the role in December 2021, described implementing the VHA national templates containing all required elements in February 2022.

Lack of service-specific criteria is a repeat finding from the 2018 comprehensive healthcare inspection.[42] The OIG closed the associated recommendation on August 6, 2019, based on evidence the leaders provided. However, the OIG found the leaders did not sustain improvement and is issuing a repeat recommendation.

Recommendation 2

2. The Chief of Staff determines the reasons for noncompliance and ensures service chiefs incorporate service-specific criteria in Ongoing Professional Practice Evaluations.

[38] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[39] VHA refers to a solo practitioner as being one provider in the facility who is privileged in a particular specialty. VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners," August 29, 2016. (This memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on December 18, 2020. The December 18, 2020, memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo: Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators on May 18, 2021.) The OIG considers few practitioners as being two providers in the facility who are privileged in a particular specialty.

[40] VHA Handbook 1100.19; VHA Directive 1100.21(1). For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

[41] The Ongoing Professional Practice Evaluation was for a nephrology solo practitioner.

[42] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Veterans Health Care System of the Ozarks*, Report No. 18-00613-275, September 18, 2018.

Healthcare system concurred.

Target date for completion: March 31, 2024

Healthcare system response: The Chief of Staff evaluated and determined there was no consistent process for the addition of service-specific criteria to the Ongoing Professional Practice Evaluation forms utilized by the facility.

The Health Systems Specialist - Credentialing and Privileging Analyst meets monthly with clinical service chiefs to conduct Ongoing Professional Practice Evaluation compliance audits. The Health Systems Specialist - Credentialing and Privileging Analyst will monitor and track facility-wide compliance results and report the results monthly to the Credentialing and Privileging Program Manager. The numerator will be the number of Ongoing Professional Practice Evaluations conducted utilizing the national service-specific clinical criteria. The denominator will be the total number of Ongoing Professional Practice Evaluations sent for review. The Credentialing and Privileging Program Manager will present the compliance results monthly to the Medical Executive Council, which is chaired by the Chief of Staff. Compliance will be tracked through the Medical Executive Council until the minimum goal of 90 percent compliance is achieved and sustained for six consecutive months.

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.[43] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[44] The physical environment of a healthcare organization must not only be functional but should also promote healing.

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG assessed compliance in selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[45]

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

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[43] 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. VHA amended this directive September 7, 2023.)

[44] VHA Directive 1608.

[45] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023.)

[46] 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.

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

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

- Emergency Department
- Medical/surgical inpatient unit (2B)
- Intensive care unit (3B)
- Mental health inpatient unit (1A)
- Women's health clinic

Environment of Care Findings and Recommendations

VHA requires the facility director to ensure staff maintain medical supplies that are "not contaminated, damaged, expired, or recalled."[48] The OIG found expired commercial sterile supplies that were more than two months past the expiration date in the medical/surgical inpatient unit and women's health clinic. The use of expired supplies may pose risks to those seeking healthcare services. The Infection Control/Multidrug-Resistant Organism Coordinator acknowledged a lack of oversight and reported believing that staff missed routine medical/surgical inpatient unit supply room inspections because the unit had been closed for at least two months. Additionally, the Registered Nurse Manager, Specialty Clinics reported believing staff overlooked swab packages in the women's health clinic during routine inventory inspections because the items were no longer in use.

Recommendation 3

3. The Director evaluates and determines any additional reasons for noncompliance and ensures staff maintain medical supplies that are not contaminated, damaged, expired, or recalled.

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

Healthcare system concurred.

Target date for completion: March 31, 2024

Healthcare system response: The Director evaluated and determined there was not a consistent process for checking all supplies in all supply storage areas. Measures were put in place to ensure compliance with monthly checking of supplies in all supply storage areas. The measures include monthly audits, a training program for current supply technicians, and a comprehensive training program for all new supply technicians. Supervisory Supply Technicians will complete monthly audits to evaluate compliance and ensure that there are no contaminated, damaged, expired, or recalled supplies present in supply storage areas and report the audit results monthly to the Supervisory Inventory Management Specialist. The Supervisory Inventory Management Specialist will report audit numerator, denominator, and compliance percentage data monthly to the Quality and Patient Safety Committee. The numerator will be the number of supply storage areas with no contaminated, damaged, expired, or recalled supplies. The denominator will be the total number of supply storage areas. Compliance will be tracked through the Quality and Patient Safety Committee, which is chaired by the Director, until a minimum of 90 percent compliance is achieved and sustained for six consecutive months.

VHA requires the chief of staff or ADPCS to ensure staff post "notices in treatment areas with overt recording announcing that the area is subject to photography or video recording."[49] The OIG found cameras recording video in the mental health inpatient unit hallways, but staff had not posted notices alerting individuals. Overt recording in patient care areas without notification infringed on individuals' rights to privacy. A nurse manager in the mental health inpatient unit and a VA police representative reported believing they met the requirement because they interpreted the VHA policy as applicable only to cameras placed inside patient rooms and not in treatment area hallways.

Recommendation 4

4. The Chief of Staff or Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure staff post notices in treatment areas with overt recording announcing the area is subject to photography or video recording.[50]

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

[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 Chief of Staff and Associate Director for Patient Care Services evaluated and determined that appropriate signage denoting video recording had previously been posted at the entrance to the Acute Inpatient Mental Health Unit but was removed during reconstruction and not replaced when completed. Notices alerting individuals that they are subject to video recording were posted to the Acute Inpatient Mental Health Unit at the entrance doors while the OIG was on site. Permanent signage alerting individuals that they are subject to video recording was placed on both entrance doors and in the sally port of the Acute Inpatient Mental Health Unit as of January 13, 2023. The Chief of Staff and the Associate Director for Patient Care Services confirmed the placement of the signage denoting video recordings in the Residential Rehabilitation Treatment Program and the Acute Inpatient Mental Health Unit locations. The Residential Rehabilitation Treatment Program located on the Veterans Health Care Center of the Ozarks campus and the Acute Inpatient Mental Health Unit are the only units with video recording and both units have permanent signage posted.

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."[51] 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."[52]

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.[53] 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."[54] 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.

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

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

[53] 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.)

[54] 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 create or update a safety plan for patients who have a positive suicide screen during an emergency department or urgent care center visit and are determined to be safe for discharge.[55] The OIG found that of the four patients who were seen in the Emergency Department and had a positive suicide risk screen, two of their electronic health records lacked evidence staff created or updated a safety plan prior to discharge. Lack of a safety plan may lead to an increased risk of suicide. The Deputy Associate Chief of Staff, Mental Health and the Suicide Prevention Coordinator did not provide a reason for the missing safety plans.

Recommendation 5

5. The Director evaluates and determines the reasons for noncompliance and ensures staff create or update safety plans for patients with a positive suicide risk screen who are determined safe to discharge home from the Emergency Department.

[55] 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."

Healthcare system concurred.

Target date for completion: January 30, 2024

Healthcare system response: The Director evaluated and determined no additional reasons for noncompliance were identified. On April 30, 2023, the system went live with the updated national Columbia Suicide Risk Evaluation template. This updated template includes risk mitigation strategies and an option to select the setting for the Emergency Department. The updated template also includes a mandatory field for the safety plan to be completed prior to discharge home from the Emergency Department. The Emergency Department Integration Software Suicide Prevention in the Emergency Department report is retrieved and reviewed weekly by the Suicide Prevention Coordinators and reported to the Associate Chief of Staff Mental Health, who then forwards this report to the executive leadership team via a PowerPoint presentation during the morning report each Wednesday. This report includes any missed opportunities and all safety plans that were completed. Twice a day the Program Analyst, Informatics sends the Suicide Prevention Coordinators a list of veterans who had a positive Columbia-Suicide Severity Rating Scale screen within the Emergency Department. The Suicide Prevention Coordinators then conduct daily audits of all those positive Columbia-Suicide Severity Rating Scale screenings to ensure a Comprehensive Suicide Risk Evaluation is completed on the same day and that a created or updated safety plan is included for patients who are determined safe to discharge home from the Emergency Department (numerator). The denominator will be the number of positive Columbia-Suicide Severity Rating Scale screens within the Emergency Department for patients determined safe to discharge home. The Suicide Prevention Coordinators will report the numerator, denominator, and compliance percentage monthly to the Quality and Patient Safety Committee. Compliance will be tracked through the Quality and Patient Safety Committee, chaired by the Medical Center Director, until a minimum compliance of 90 percent is achieved and sustained for six consecutive months.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided five recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• Leaders conduct institutional disclosures for applicable sentinel events.
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs incorporate service-specific criteria in Ongoing Professional Practice Evaluations.
Environment of Care	• Staff maintain medical supplies that are not contaminated, damaged, expired, or recalled. • Staff post notices in treatment areas with overt recording announcing the area is subject to photography or video recording.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Staff create or update safety plans for patients with a positive suicide risk screen who are determined safe to discharge 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 16.[1]

Table B.1. Profile for Veterans Health Care System of the Ozarks (564) (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	$364,881,688	$508,832,608	$625,166,736
Number of:			
• Unique patients	53,893	54,799	55,981
• Outpatient visits	604,747	588,272	669,025
• Unique employees§	1,393	1,529	1,625
Type and number of operating beds:			
• Domiciliary	20	20	20
• Medicine	30	30	30
• Mental health	15	15	15
• Surgery	5	5	5
Average daily census:			
• Domiciliary	11	9	4
• Medicine	15	13	15
• Mental health	10	7	6
• Surgery	1	1	1

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), October 1, 2020. 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: September 29, 2023

From: Director, South Central VA Health Care Network (10N16)

Subj: Comprehensive Healthcare Inspection of the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

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

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

1. The South Central VA Health Care Network has reviewed and concurs with the recommendations in the OIG report entitled Comprehensive Healthcare Inspection of the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas. Further, I have reviewed and concur with the facility's response to the recommendations.
2. If you have questions regarding the information submitted, please contact VISN 16 Quality Management Officer.

(Original signed by:)

Shannon C. Novotny, MPA, FACHE
Deputy Network Director
On behalf of
Skye McDougall, PhD
VISN 16 Network Director

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: September 14, 2023

From: Director, Veterans Health Care System of the Ozarks (564)

Subj: Comprehensive Healthcare Inspection of the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of the Veterans Health Care System of the Ozarks in Arkansas. I will ensure that each recommendation is addressed. I concur with the recommendations.
2. The Veterans Health Care System of the Ozarks remains committed to ensuring our Veterans receive exceptional healthcare.

(Original signed by:)

George Velez, DHA, MBA, FACHE
Medical Center Director/CEO

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