US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Overton Brooks VA Medical Center in Shreveport, Louisiana

CHIP Report	22-00240-17	November 15, 2023

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Figure 1. *Overton Brooks VA Medical Center in Shreveport, Louisiana.*
Source: https://www.va.gov/shreveport-health-care/.

Abbreviations

AED	Automated External Defibrillator
CHIP	Comprehensive Healthcare Inspection Program
ED	emergency department
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Overton Brooks VA Medical Center and multiple outpatient clinics in Arkansas, Louisiana, and Texas. 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 Overton Brooks VA Medical Center during the week of August 15, 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 medical center'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 medical center 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 15 recommendations to the Medical Center Director, Chief of Staff, and Associate Director in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. These opportunities for improvement are detailed throughout the report, and the recommendations are summarized in appendix A on page 32.

Conclusion

The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. 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 Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 35-36, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 6, 7, 9, 10, 11, 12, and 14 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 Overton Brooks VA Medical Center 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 medical center 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 (ED) 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 Overton Brooks VA Medical Center includes community-based outpatient clinics serving veterans in Arkansas, Louisiana, and Texas. General information about the medical center can be found in appendix B.

The inspection team examined operations from October 29, 2016, through August 19, 2022, the last day of the unannounced multiday evaluation.[5] After the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

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 medical center leaders complete corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that medical center 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 Clinical Assessment Program review of the Overton Brooks VA Medical Center occurred in October 2016. The Joint Commission (TJC) performed hospital, behavioral health care and human services, and home care accreditation reviews March 30 to April 2, 2021, and a laboratory accreditation review in May 2021.

[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 medical center'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 medical center 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 medical center had a leadership team consisting of the Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Services, Associate Director, and Assistant Director. The Chief of Staff and Associate Director for Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for approximately one and a half years, although the Director had been in the role since 2017, and the Chief of Staff had served for more than three years. To help assess the executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

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[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 medical center's fiscal year (FY) 2021 annual medical care budget of $485,106,645 had increased by approximately 17 percent compared to the previous year's budget of $414,565,181.[10] The Director stated that the medical budget was sufficient to hire physicians; however, the way the money was allocated created ongoing challenges in funding staff to support the physicians. The Associate Director added that funding community care remained difficult, as did retaining nurses.[11]

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[13]

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

[11] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed January 25, 2023, https://www.va.gov/communitycare/.

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

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

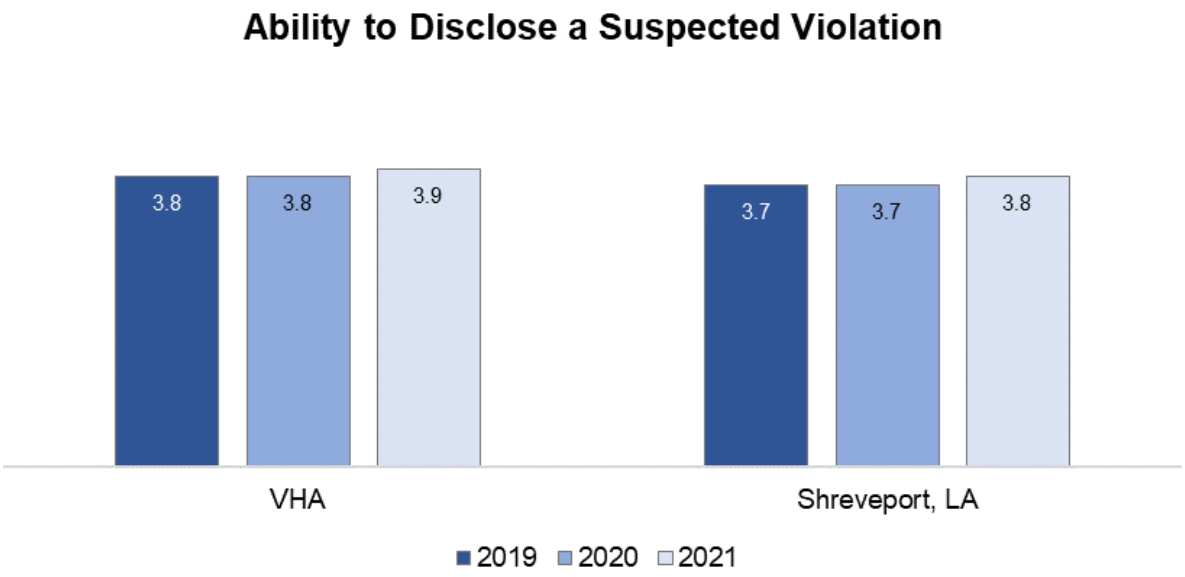

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

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

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

Patient Experience

Veterans Health Administration (VHA) uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.[14]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the medical center over time.[16]

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

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

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

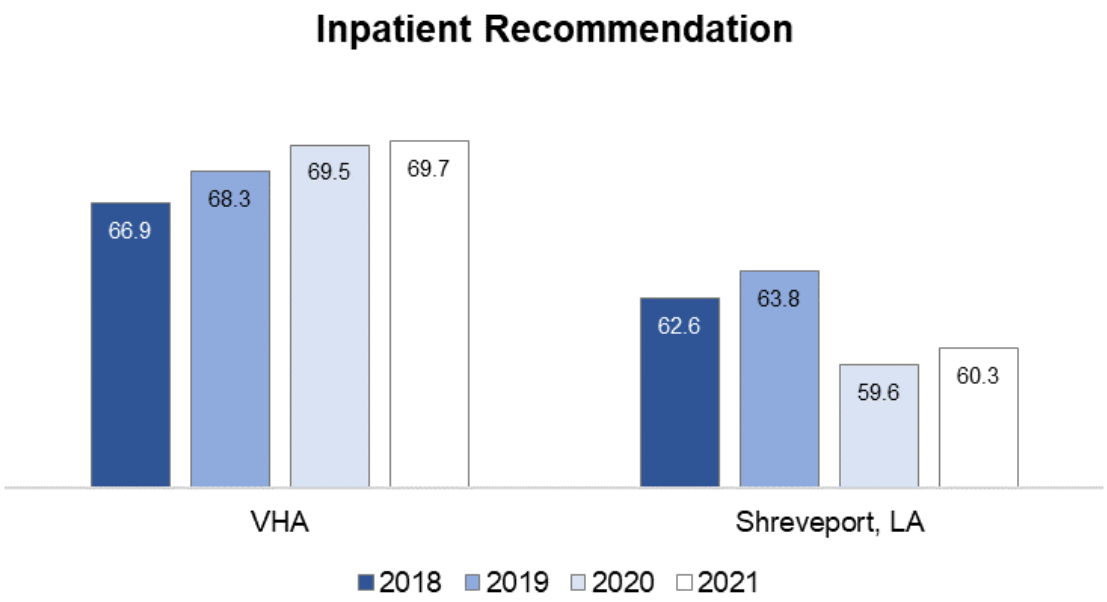

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

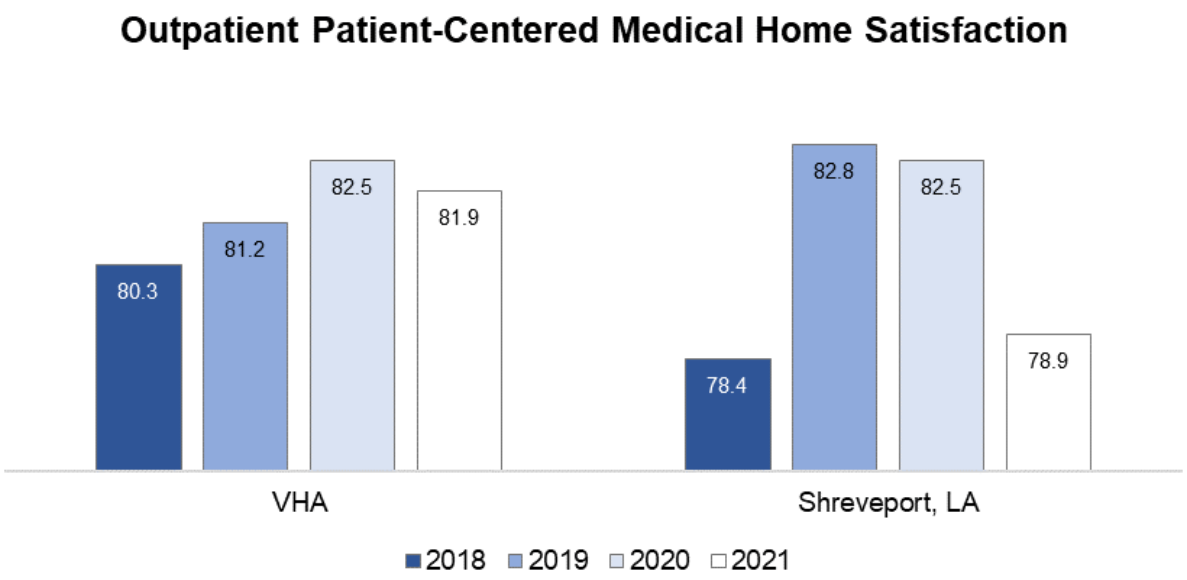

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

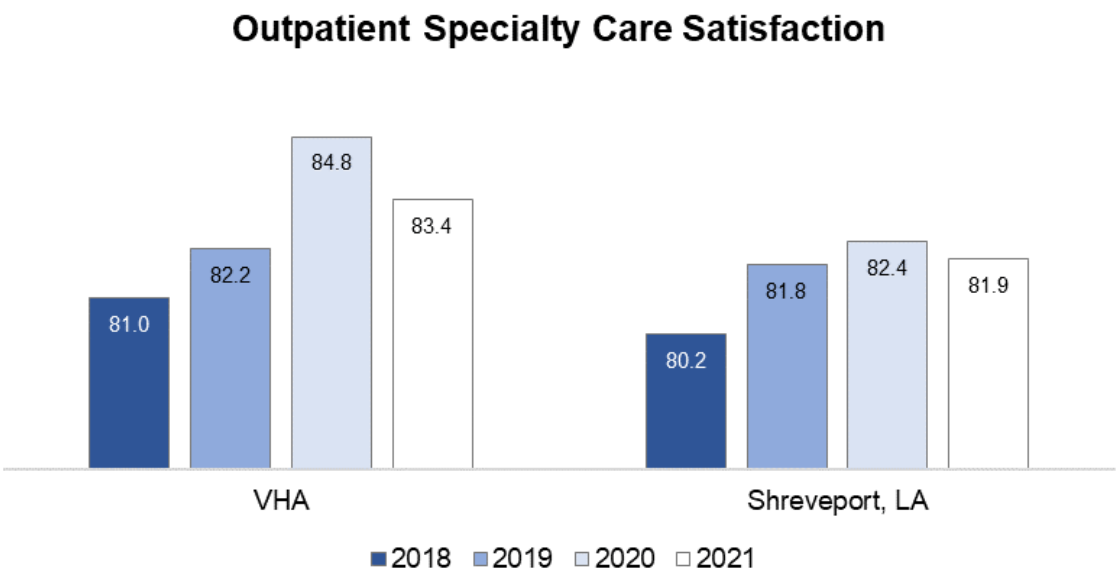

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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 Medical Center Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] "A sentinel event is 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)."[18] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and

[17] 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/.

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

recourse."[19] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[20] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's (TJC's) standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[21] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[22]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred from October 29, 2016, to August 15, 2022, and reviewed the information staff provided. The Director discussed reviewing patient safety reports daily, assessing the number of events reported, and looking for ways to recognize staff who submitted them. Additionally, the Director reported being notified of patient safety events by the Patient Safety Manager or other members of the Quality, Safety, Value team. According to the Director, leaders also discuss patient safety events during weekly town hall meetings with 300 to 400 attendees.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[20] VHA Directive 1004.08.

[21] TJC, *Standards Manual*, E-dition, July 1, 2022.

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

Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[23] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain TJC accreditation.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from TJC).[25]

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the medical center'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 medical center's processes for conducting peer reviews of clinical care.[26] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[27] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[28]

Finally, the OIG assessed the medical center's culture of safety.[29] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

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

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

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

[25] VHA Directive 1100.16.

[26] A peer review is a "critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[27] VHA Directive 1190.

[28] VHA Directive 1190.

[29] A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, accessed October 3, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[30] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[31]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[32] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[33]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE 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 (OPPE) to ensure the continuous delivery of quality care.[34]

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.[35] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the chief of staff. VHA also requires facilities to have credentialing

[30] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (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.)

[31] VHA Handbook 1100.19.

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[36]

The OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members who had an FPPE or OPPE.

Medical Staff Privileging Findings and Recommendations

For all new privileges granted, VHA requires service chiefs to assess LIPs' professional performance using the FPPE process.[37] The OIG did not find evidence service chiefs consistently completed FPPEs. As a result, the LIPs may have continued to deliver care without an evaluation of their practices, which could have adversely affected quality of care and patient safety. The acting Deputy Chief of Staff and Chief of Staff stated that service chiefs may not have fully understood the FPPE process and requirements.

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs complete Focused Professional Practice Evaluations for all licensed independent practitioners.

[36] 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.

[37] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. The Service Chief shall take responsibility for overseeing the completion of Focused Professional Practice Evaluations (FPPE) for all licensed independent practitioners within their respective clinical service areas and name a Service Point of Contact for Focused Professional Practice Evaluations. The Clinical Service Points of Contact will track this process and report to Credentialing and Privileging for monitoring. This includes ensuring that Focused Professional Practice Evaluations are initiated, conducted, closed, and reported to the Professional Standards Board in a timely manner. The Chief of Staff office will provide support and guidance to the Service Chiefs and their Points of Contact in carrying out this responsibility. The numerator is the total number of Focused Professional Practice Evaluations presented to the Professional Standards Board for closure and the denominator is the total number of Focused Professional Practice Evaluations due to be completed and presented to the Professional Standards Board. This will be monitored and reported to the Professional Standards Board monthly until six consecutive months of 90 percent compliance is documented.

VHA required practitioners with similar training and privileges to evaluate LIPs.[38] The OIG reviewed OPPEs and found inconsistent evidence that similarly trained and privileged practitioners completed the evaluations. This could result in LIPs providing care without a thorough evaluation of their practice, which could jeopardize quality of care and patient safety. The acting Deputy Chief of Staff attributed noncompliance to ongoing process challenges.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures practitioners with equivalent specialized training and similar privileges complete licensed independent practitioners' professional practice evaluations.

[38] 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.) VHA now requires another practitioner with equivalent specialized training and similar privileges to complete the professional practice evaluation. VHA Directive 1100.21(1).

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. To meet this recommendation, the Chief of Staff office will ensure that the Credentialing Manager conducts regular audits of all practitioner professional practice evaluations, with a focus on practitioners with equivalent specialized training and similar privileges. The Chief of Staff office will also oversee the provision of immediate education to Service Chiefs who are found to be noncompliant during these audits, providing clear instructions for correction. Furthermore, the Chief of Staff office will monitor the biannual reporting of delinquent ongoing professional practice evaluations to the Medical Executive Board, as well as the weekly updates provided to the Chief of Staff. This oversight will continue until targeted compliance of at least 90 percent is achieved for two consecutive quarters. The numerator is the number of Ongoing Professional Practice Evaluations meeting the requirements regarding equivalent specialized training and similar privileges and the denominator is all Ongoing Professional Practice Evaluations presented to the Professional Standards Board.

VHA requires service chiefs to incorporate service-specific criteria in professional practice evaluations.[39] The OIG determined there was inconsistent evidence of service-specific criteria in the OPPEs reviewed. This may have resulted in LIPs providing care without a thorough evaluation of their competency. The acting Deputy Chief of Staff acknowledged that some OPPE review forms did not specify service-specific criteria but thought these forms met the criteria.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs incorporate service-specific criteria in licensed independent practitioners' professional practice evaluations.

[39] 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.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. To meet this recommendation, the Chief of Staff office will take [the] lead in ensuring that all Ongoing Professional Practice Evaluation forms include the necessary clinical indicators relevant to their respective clinical service areas. The Chief of Staff office will provide oversight and monitoring to ensure compliance with this requirement. Concurrently, the Credentialing Manager will continue to report the progress and compliance status to the appropriate boards, providing regular updates on the inclusion of service-specific criteria on Ongoing Professional Practice Evaluation forms. The Chief of Staff office will oversee the immediate provision of education to noncompliant Service Chiefs, ensuring they receive clear instructions for correction. The numerator is the number of Ongoing Professional Practice Evaluation forms meeting requirements regarding [service-specific] clinical indicators and the denominator will be all Ongoing Professional Practice Evaluation forms presented to the Professional Standards Board. Tracking will continue until six consecutive months of 90 percent compliance noted and documented in the Professional Standards Board.

VHA requires service chiefs to consider relevant OPPE data when recommending the continuation of LIPs' privileges, which may include direct observation, clinical discussions with other members of the care team, and review of diagnoses and treatments.[40] The OIG found that service chiefs did not consistently use OPPE data in recommending the continuation of LIPs' privileges. The Chief of Staff explained that service chiefs provided a verbal attestation to recommend continuance of current privileges but did not provide documentation of OPPE data. The Chief of Staff further stated that this process was in place under the previous Chief of Staff and reported being unaware that verbal attestation was insufficient to meet requirements.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs consider relevant Ongoing Professional Practice Evaluation data in reprivileging recommendations.

[40] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. To meet this recommendation, the Chief of Staff office, in collaboration with the Service Chiefs, shall ensure that all practitioners' Ongoing Professional Practice Evaluations data is thoroughly reviewed for the current appointment period and results taken in[to] consideration prior to making recommendations for reappointment. This comprehensive review process will be conducted to verify that the practitioner's performance meets all necessary requirements and standards. The Credentialing Manager shall conduct audits of all practitioners professional practice evaluations for licensed independent practitioners prior to [the] file being presented to the Professional Standards Board. Furthermore, the Chief of Staff office will ensure that all members of the Professional Standards Board review and confirm the outcomes of practitioner professional practice evaluations before voting on re-privileging actions. Finally, the Chief of Staff office will ensure that the outcomes of practitioner professional practice evaluations are accurately documented in the minutes of the Professional Standards Board meetings. This will be tracked in the Professional Standards Board until six consecutive months of 90 percent compliance is maintained. The numerator is the number of Ongoing Professional Practice Evaluations with data used in reprivileging decision[s] by the Professional Standards Board and the denominator is the total number of all Licensed Independent Practitioners presented to Professional Standards Board.

VHA requires the executive committee of the medical staff (known as the Medical Executive Board at this medical center) to recommend privileges based on professional practice evaluation results.[41] The OIG found that the Medical Executive Board did not consistently use professional practice evaluation results to recommend privileges for LIPs. This may have resulted in LIPs continuing to deliver care without thorough evaluations of their practices. The Chief of Staff said the current process does not require service staff to return any completed professional practice evaluation documentation to the Credentialing and Privileging Office for review or storage. Further, the Chief of Staff stated that this lack of centralized storage and oversight may have led to inconsistent availability of the results for use by the Medical Executive Board.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Medical Executive Board uses professional practice evaluation results to recommend privileges for licensed independent practitioners.

[41] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. To meet this recommendation, the Chief of Staff office will oversee the requirement that Service Chiefs review and include information regarding the practitioner's professional practice evaluation for all licensed independent practitioners that are being recommended for re-privileging. Furthermore, the Chief of Staff office will ensure that all members of the Professional Standards Board review and confirm the outcomes of practitioner professional practice evaluations before voting on re-privileging actions. The Chief of Staff office will also ensure that the outcomes of practitioner professional practice evaluations are accurately documented in the minutes of Professional Standards Board meetings. Finally, the Chief of Staff office will oversee the use of these professional practice evaluation results by the Medical Executive Board to make recommendations regarding privileges for licensed independent practitioners. This will be monitored until six consecutive months of 90 percent compliance is maintained and documented in the Professional Standards Board [meeting minutes]. The numerator is the number of Ongoing Professional Practice Evaluations results used in the reprivileging decision by the Professional Standards Board and the denominator is the total number of Ongoing Professional Practice Evaluations presented to the Professional Standards Board.

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.[42] 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.[43]

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.[44] 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 (AED) cabinets in nontraditional patient care areas to enable fast response times during emergencies and contribute to a safe healthcare environment.[45]

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

- Dental Clinic
- Dialysis Unit (4 East)

[42] 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.)

[43] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.)

[44] 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.

[45] 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 (ED)
- Inpatient Mental Health (9 East)
- Intensive care unit (3 North)
- Medical/surgical inpatient unit (6 West)
- Primary Care Red Team

Environment of Care Findings and Recommendations

VHA requires staff to conduct environment of care inspections "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is delivered."[46] The OIG found that staff did not inspect 10 patient care areas twice in FY 2021.[47] This may have resulted in staff failing to proactively identify and correct potentially unsafe conditions. The Occupational Health and Safety Specialist reported that 3 patient care areas were considered business areas according to TJC and only required inspections once per fiscal year.[48] For the remaining 7 noncompliant areas, the Occupational Health and Safety Specialist indicated that staff did not complete all inspections because they misinterpreted the requirements.

Recommendation 6

6. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures staff conduct environment of care inspections in patient care areas at the required frequency.[49]

[46] VHA Directive 1608.

[47] The deficient areas included 5 West Specialty Clinics, 5 East Urology/Neurology Clinic, 4 West Radiology Clinic, 2 South Outpatient Mental Health/PTSD [post-traumatic stress disorder] Clinic, 2AE PC [primary care] Red Team, 1AE PC [primary care] Blue and White Teams, BE (Basement East) (Annex) ENT [Ear, Nose, Throat] Radiology/Oncology, BW (Basement West) Audiology/Speech Pathology Clinic, 4N-PMRS (Physical Medicine & Rehab Service), and BS-SUDS (Basement South-Substance Use Disorders).

[48] TJC, *Standards Manual*, E-dition, LS.01.01.01, January 1, 2020. The deficient areas included 5W Specialty Clinics, 2 South Outpatient Mental Health/PTSD Clinic, and BE ENT Radiation/Oncology.

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

Medical center concurred.

Target date for completion: Completed

Medical center response: The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance. In September of 2022, the Safety Engineer Supervisor revised the inspection criteria for both non-patient and patient care areas ensuring that all inspections are completed at the required frequency. All Environment of Care inspections are being completed a minimum of twice per year as VHA Directive 1608 states, and have been documented on a tracking form. Also, first line supervisors were added to bring additional focus and a greater footprint for our inspections. Overton Brooks VA Medical Center has been in full compliance with this recommendation since September 2022, maintaining greater than 90 percent compliance for a year.

VHA requires that AED cabinets containing naloxone have alarms set in the "on" position, contain tamper-evident seals, display laminated "N" signs, and include naloxone inspection logs and administration reference cards.[50] The OIG inspected five AED cabinets containing naloxone and found that none had the alarm set in the "on" position.[51] Additionally, one cabinet had a seal that was not tamper-evident; two cabinets did not have laminated "N" signs displayed or inspection logs documenting the naloxone as secured and unexpired; and four cabinets lacked nasal naloxone administration reference cards.[52] These conditions may prevent the detection of an audible alarm if an AED cabinet door is open, recognition of AED cabinets containing naloxone, assurance that AED cabinets are secured and the naloxone is unexpired, and accurate and effective administration of nasal naloxone in the event of an opioid overdose.

The Chief of Pharmacy Service said the laminated "N" sign indicating the AED cabinet contains nasal naloxone for the Dental Clinic was peeled off and not replaced, and staff removed the reference cards for nasal naloxone administration and did not replace them when changing out the expired naloxone in the Dental, Podiatry, and Eye clinics. The Dental Clinic Administrative Officer reported that staff used a previous version of an AED log that did not address nasal naloxone. The Chief of Pharmacy Service reported lack of oversight as a reason for noncompliance.

[50] "Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit," VHA.

[51] AED cabinets were in the Dental Clinic (rooms 116 and 216), Eye Clinic (room 123), Podiatry Clinic (room 208), and Women's Health Clinic (room 316).

[52] The OIG found deficiencies in the Dental Clinic (rooms 116 and 216), Eye Clinic (room 123), and Podiatry Clinic (room 208).

Recommendation 7

7. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures Automated External Defibrillator cabinets containing naloxone have alarms set in the "on" position, contain tamper-evident seals, display laminated "N" signs, and include naloxone inspection logs and administration reference cards.[53]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance. In November of 2022, Pharmacy Leadership met and discussed processes to assure Automated External Defibrillator cabinets are compliant with VHA requirements. It was determined that all approved medication storage areas must be inspected by pharmacy personnel monthly utilizing VA Form 10-0053 Medication Inspection Form for Wards and Clinics, and all areas with Automated External Defibrillators are part of this monthly inspection. VA Form 10-0053 was updated to include a check list of all required documentation for the Automated External Defibrillator cabinet to meet VHA requirements, which includes Automated External Defibrillator cabinets with Intranasal Naloxone have "N" on the outside; Naloxone is within its expiration date; Automated External Defibrillator cabinets are locked, and alarm is in the "ON" position; and instructions for Naloxone use is in the Automated External Defibrillator cabinet. In December of 2022, the updated VA Form 10-0053 was implemented. Compliance has been documented for the areas identified by OIG (Dental Clinic, Womens Clinic, and Podiatry Clinic). The completed forms are reviewed monthly for compliance and reported to the Pharmacy and Therapeutics Committee. Naloxone inspection logs are in place on each Automated External Defibrillator containing naloxone. Overton Brooks VA Medical Center has been in full compliance with this recommendation since December 2022, maintaining greater than 90 percent compliance for at least six consecutive months.

VHA requires staff to check the inventory in clean or sterile storerooms and remove expired or damaged supplies.[54] The OIG found expired medical supplies in the ED medication room and medical/surgical inpatient unit's clean supply room. The use of expired supplies may pose risks to patients due to loss of reliability. The Overton Brooks VA Medical Center OIG Specialist reported the Associate Director for Patient Care Services said nursing staff did not remove the ED's expired medical supplies because they do not have a strong process for checking expiration dates. The Associate Director stated the Chief of Logistics reported a technician checked the

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

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

medical/surgical inpatient unit's clean supply room every morning for expired supplies but overlooked them.

Recommendation 8

8. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures staff check inventory in clean storerooms and remove expired supplies in the Emergency Department and medical/surgical inpatient unit.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance. The Chief Supply Chain Officer also evaluated the recommendation and determined that the expired supplies within the Emergency Department were in two separate locations, one of which is not monitored by Supply Chain Management. The Emergency Department's supplies are tracked by a network-connected, electronically monitored inventory management system. Inventory is checked weekly by supply chain management personnel to ensure there are no expired supplies in each Logistics-managed supply area. Any expired items found are immediately removed by supply chain management personnel. The Temptrak, humidity-controlled supply rooms in the Emergency Department and our medical-surgical units (7 West and 8 West) will be inspected monthly for expired supplies by the logistics management specialist. The VISN standard secondary closet inspection form will be utilized. These areas will be inspected monthly until six consecutive months of 90 percent compliance is achieved and will be reported to Quality, Safety and Value Board.

VHA requires staff to minimize the infection risk related to medical supplies.[55] The OIG found soiled floors in the Dialysis Unit's clean storage and medical/surgical inpatient unit's clean supply rooms, which may increase the risk of medical supplies becoming contaminated. The Chief of Environmental Management Service reported that dirty floors were due to lack of oversight and environmental management staff's inattention to detail.

[55] VHA Directive 1761.

Recommendation 9

9. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures the Chief of Environmental Management Service maintains clean floors in the Dialysis Unit and medical/surgical inpatient unit clean storage and supply rooms.[56]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director reviewed this recommendation and did not identify any additional reasons for non-compliance. Environmental Management Service corrected the identified deficiencies. The clean storage and supply room floors in the Dialysis Unit and in our Medical/Surgical units have been cleaned. Environmental Management Service recruited for and filled the vacant Quality Assurance/Training Specialist position on 1/29/2023 to assist with any identified deficiencies with frontline operational oversight.

TJC standards specify that the medical center "establishes and maintains a safe, functional environment."[57] The OIG found a rusty sink basin and foot pedals in the Dialysis Unit's clean storage room, and a dirty and stained sink in a medical/surgical inpatient unit room. As a result, staff may not have been able to ensure a clinical environment that supports positive patient outcomes and promotes patient safety. The Chief of Engineering reported being unaware of the rusty sink and foot pedals because unit staff did not submit a service request. The Chief of Environmental Management Service attributed the dirty and stained sink to lack of oversight and environmental management staff's inattention to detail.

Recommendation 10

10. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures staff maintain safe and functional environments in the Dialysis Unit and medical/surgical inpatient unit.[58]

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

[57] TJC, *Standards Manual*, E-dition, EC.02.06.01, January 1, 2022.

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

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director evaluated this recommendation and found no additional reasons for noncompliance. The rust removal process on the foot pedal of the sink in our Dialysis Unit took place on September 13, 2023, with the rust's origin traced back to the oxidation of the dialysis chemicals on the metal surface. No rust is present on the foot pedals. Environmental Management Service staff have ensured that the sink in our Dialysis Unit is clean, along with the identified sink on our medical/surgical unit. Environmental Management Service recruited for and filled the vacant Quality Assurance/Training Specialist position on 1/29/2023 to assist with any identified deficiencies with frontline operational oversight.

TJC specifies that staff keep "furnishings and equipment safe and in good repair."[59] The OIG found damaged furnishings exposing bare wood in patient care rooms in the intensive care and medical/surgical inpatient units. This may have prevented effective cleaning and disinfection of the furnishings. The Chief of Engineering indicated being unaware of the damage due to inattention to detail and lack of service requests submitted by unit staff.

Recommendation 11

11. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures staff keep furnishings safe and in good repair in the intensive care and medical/surgical inpatient units.[60]

[59] TJC, *Standards Manual*, E-dition, EC.02.06.01, EP 26, January 1, 2022.

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

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director reviewed this recommendation and did not identify any additional reasons for non-compliance. Environmental Management Service (EMS) has removed and replaced the furnishings that were identified during OIG's visit. Environmental Management Service recruited and filled the vacant Quality Assurance/Training Specialist position on January 29, 2023, to address deficiencies with frontline operational oversight. Environmental Management Service also recruited and filled the vacant Interior Designer position on November 20, 2022, to address deficiencies with oversight pertaining to furnishings. Environmental Management Service requested and has been approved for a second Interior Designer position and four maintenance worker positions to support functions related to Interior Design component of Environment of Care.

TJC specifies staff ensure "[i]nterior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided."[61] The OIG found holes in the walls of the Dental Clinic and ED.[62] Additionally, the OIG found multiple stained ceiling tiles in the ED and Primary Care Red Team. As a result, staff may have been unable to ensure a safe, clean, and functional clinical environment for patients and staff. The Chief of Engineering said personnel did not repair the holes in the walls due to inattention to detail, and because unit staff did not submit service requests. Additionally, the Chief of Engineering reported being unaware of the stained ceiling tiles, which were likely caused by a recent rainstorm, due to inattention to detail and lack of service requests.

Recommendation 12

12. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures staff repair damaged walls in the Dental Clinic and Emergency Department.[63]

[61] TJC, *Standards Manual*, E-dition, EC.02.06.01, EP 1, January 1, 2022.

[62] The OIG observed holes in walls in the Dental Clinic (room 122) and ED (room 1N20).

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

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director evaluated this recommendation and found no additional reasons for noncompliance. The damaged walls in both the Dental Clinic and Emergency Department were assessed by our Engineering Service staff and were fixed on August 17, 2022, and August 22, 2022, respectively. Damage to walls will be noted during Environment of Care rounds, documented, and corrected.

Recommendation 13

13. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures staff replace stained ceiling tiles in the Emergency Department and Primary Care Red Team.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Associate Director evaluated this recommendation and identified facility roof issues as an additional reason for noncompliance. Roofing replacement over the Primary Care Red Team area has been initiated as of September 18, 2023. The Emergency Department roof contract was awarded August 15, 2023, with an estimated completion date of June 28, 2024. Ceiling tiles in Primary Care Red Team were replaced on August 16, 2022, and August 14, 2023. The Emergency Department ceiling tiles were replaced on August 16, 2022, and August 14, 2023. The Management and Program Analyst in Engineering Service will perform a monthly inspection for stained tiles in the two areas identified and replace any ceiling tile found stained. A tracking sheet will be utilized to document monthly inspections until six consecutive months of 90 percent compliance is achieved. This will be reported in the Environment of Care Committee meeting. For compliance, the numerator is the number of areas checked monthly and the denominator is the two areas that are scheduled to be checked.

In areas designated as secure and personal and where recording equipment is being used, VHA requires staff to post signage indicating the area "may be subject to photography, digital imaging or video or audio recording."[64] The OIG found cameras in use but no signage in the intensive care and medical/surgical inpatient units, Dental Clinic, and Primary Care Red Team. This may have resulted in individuals not being informed the area is subject to video recording and could infringe on privacy expectations. The Deputy Chief of Police reported being unaware of the requirement.

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

Recommendation 14

14. The Medical Center Director determines any additional reasons for noncompliance and ensures staff post signage where recording equipment is used in the intensive care and medical/surgical inpatient units, Dental Clinic, and Primary Care Red Team indicating the areas are subject to photography, digital imaging, video, or audio recording.[65]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director evaluated this recommendation and did not identify any additional reasons for noncompliance. As of September 18, 2023, signs stating that electronic surveillance is in use have been placed at all facility entrances, and at Dental Clinic, Primary Care Red Team, our intensive care unit and in our medical-surgical units.

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

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."[66] 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."[67]

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.[68] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in EDs 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 EDs or urgent care centers and receive "structured post-discharge follow-up to facilitate engagement in outpatient mental health care."[69] The OIG assessed the medical center for its adherence to staff completion of suicide safety plans prior to patients' discharge from EDs or urgent care centers and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 48 randomly selected patients who were seen in the ED or urgent care center from December 31, 2020, through August 1, 2021.

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

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

[68] 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.)

[69] 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 that all patients who screen positive for suicide risk in the ED or urgent care center have a Comprehensive Suicide Risk Evaluation that includes assessment of whether the patient's most recent suicide attempt was their most lethal.[70] The OIG determined that providers did not assess whether the most recent suicide attempt was the most lethal for one of eight patients. The provider's failure to complete all elements of the evaluation could have resulted in an increased risk of the patient's suicide. A social worker stated the provider overlooked completing the element because of familiarity with the patient and professional judgment.

Recommendation 15

15. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers assess whether patients' most recent suicide attempt was their most lethal when completing the Comprehensive Suicide Risk Evaluation.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Chief of Staff reviewed the recommendation and did not identify any additional reason for noncompliance. In efforts to improve the rate of compliance of our providers' assessment of whether patients' most recent suicide attempt was their most lethal, our Chief of Staff's Office will send an email to all providers at our facility instructing them that all aspects of the Comprehensive Suicide Risk Evaluation must be completed, including whether the patients' most recent suicide attempt was the most lethal. The Suicide Prevention Program Manager will track providers' compliance. The numerator will be how many Comprehensive Suicide Risk Evaluations of patients who had a positive Columbia-Suicide Severity Rating Scale [screen] in the Emergency Department had an adequate assessment of most lethal [suicide] attempt and the denominator will be the number of Comprehensive Suicide Risk Evaluations completed per month for patients who had positive Columbia-Suicide Severity Rating Scale [screen] in the Emergency Department. This data will be tracked and reported monthly to Quality, Safety and Value Board until 90 percent compliance can be shown for at least six consecutive months.

[70] 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);" 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)."

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 medical center, the OIG conducted a detailed review of five clinical and administrative areas and provided 15 recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this medical center. 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 15 OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Medical Center Director, Chief of Staff, and Associate Director. 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	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs complete Focused Professional Practice Evaluations for all licensed independent practitioners. • Practitioners with equivalent specialized training and similar privileges complete licensed independent practitioners' professional practice evaluations. • Service chiefs incorporate service-specific criteria in licensed independent practitioners' professional practice evaluations. • Service chiefs consider relevant Ongoing Professional Practice Evaluation data in reprivileging recommendations. • The Medical Executive Board uses professional practice evaluation results to recommend privileges for licensed independent practitioners.

Healthcare Processes	Recommendations for Improvement
Environment of Care	• Staff conduct environment of care inspections in patient care areas at the required frequency. • Automated External Defibrillator cabinets containing naloxone have alarms set in the "on" position, contain tamper-evident seals, display laminated "N" signs, and include naloxone inspection logs and administration reference cards. • Staff check inventory in clean storerooms and remove expired supplies in the Emergency Department and medical/surgical inpatient unit. • The Chief of Environmental Management Service maintains clean floors in the Dialysis Unit and medical/surgical inpatient unit clean storage and supply rooms. • Staff maintain safe and functional environments in the Dialysis Unit and medical/surgical inpatient unit. • Staff keep furnishings safe and in good repair in the intensive care and medical/surgical inpatient units. • Staff repair damaged walls in the Dental Clinic and Emergency Department. • Staff replace stained ceiling tiles in the Emergency Department and Primary Care Red Team. • Staff post signage where recording equipment is used in the intensive care and medical/surgical inpatient units, Dental Clinic, and Primary Care Red Team indicating the areas are subject to photography, digital imaging, video, or audio recording.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Providers assess whether patients' most recent suicide attempt was their most lethal when completing the Comprehensive Suicide Risk Evaluation.

Appendix B: Medical Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated medical center reporting to VISN 16.[1]

Table B.1. Profile for Overton Brooks VA Medical Center (667) (October 1, 2018, through September 30, 2021)

Profile Element	Medical Center Data FY 2019*	Medical Center Data FY 2020†	Medical Center Data FY 2021‡
Total medical care budget	$354,191,594	$414,565,181	$485,106,645
Number of:			
• Unique patients	38,600	37,684	38,194
• Outpatient visits	451,574	405,781	421,888
• Unique employees§	1,403	1,411	1,445
Type and number of operating beds:			
• Intermediate	5	5	5
• Medicine	50	50	50
• Mental health	16	12	12
• Surgery	24	24	24
Average daily census:			
• Intermediate	3	11	7
• Medicine	42	39	40
• Mental health	9	8	6
• Surgery	6	5	4

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

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

**October 1, 2018, through September 30, 2019.*
†*October 1, 2019, through September 30, 2020.*
‡*October 1, 2020, through September 30, 2021.*
§*Unique employees involved in direct medical care (cost center 8200).*

[1] VHA medical facilities are classified according to a complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center 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 25, 2023

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

Subj: Comprehensive Healthcare Inspection of the Overton Brooks VA Medical Center in Shreveport, Louisiana

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

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 Overton Brooks Veterans Affairs Medical Center, Shreveport, Louisiana. 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:)

Skye McDougall, PhD
VISN 16 Network Director

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: September 11, 2023

From: Medical Center Director, Overton Brooks VA Medical Center (667)

Subj: Comprehensive Healthcare Inspection of the Overton Brooks VA Medical Center in Shreveport, Louisiana

To: Network Director for 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 Overton Brooks VA Medical Center. I concur with the recommendations in the report.
2. Overton Brooks VA Medical Center remains committed to ensuring our Veterans receive health care of the highest quality.

(Original signed by:)

Richard L. Crockett, MBA
Medical Center Director
Overton Brooks VA Medical Center (667/00)

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  Arkansas: John Boozman, Tom Cotton
  Louisiana: Bill Cassidy, John Kennedy
  Texas: John Cornyn, Ted Cruz
US House of Representatives
  Arkansas: Bruce Westerman
  Louisiana: Mike Johnson, Julia Letlow
  Texas: Brian Babin, Pat Fallon, Nathaniel Moran

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