US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

CHIP Report | 23-00004-37 | December 19, 2023

BE A

VOICE FOR VETERANS

REPORT WRONGDOING

va.gov/oig/hotline | 800.488.8244

OUR MISSION

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

CONNECT WITH US

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

PRIVACY NOTICE

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

Figure 1. *W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina. Source: https://www.va.gov/salisbury-health-care/locations (accessed March 13, 2023).*

Abbreviations

ADPCS	Associate Director of Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
COS	Chief of Staff
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 W.G. (Bill) Hefner VA Medical Center, which includes multiple outpatient clinics in North Carolina. 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 suicide prevention initiatives)

The OIG initiated an unannounced inspection of the W.G. (Bill) Hefner VA Medical Center during the week of January 9, 2023. 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 and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued four recommendations to the Chief of Staff in the Mental Health area of review. 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. The results are detailed in the Mental Health report section, and the recommendations are summarized in appendix A on page 20.

VA Comments

The Veterans Integrated Service Network Director and interim Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 23–24, and the responses within the body of the report for the full text of the directors' comments). 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 W.G. (Bill) Hefner 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 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): 13, 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 (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The W.G. (Bill) Hefner VA Medical Center also provides care through multiple outpatient clinics in North Carolina. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review during the week of January 9, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until medical center leaders complete corrective actions. The interim Medical Center Director's responses to the report recommendations appear within the associated 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 W.G. (Bill) Hefner VA Medical Center occurred in May 2021. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in June 2021 and a laboratory accreditation review in November 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 organization's 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 the following 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 Director, Chief of Staff (COS), Associate Director of Patient Care Services (ADPCS), Associate Director, and Assistant Director. The COS and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for approximately six months since the Director's appointment in July 2022. Having started in August 2016, the ADPCS was the most tenured member of the executive team. The COS, Associate Director, and Assistant Director had each served for approximately 15 months.

[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.

To help assess executive leaders' engagement, the OIG interviewed the Director, COS, ADPCS, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $1,057,189,382 had increased by approximately 5 percent compared to the previous year's budget of $1,006,272,651.[10] The Director reported using funds to achieve the appropriate staffing levels in patient aligned care teams (primary care), the community living center, and inpatient care areas.[11] The COS said nursing shortages had caused leaders to reduce available inpatient, mental health, and community living center beds, so leaders used funds to pay for patients' care in the community.[12] The Director reported focusing on returning community care to the VA medical center, where patients preferred being seen. The COS added that leaders had prioritized approvals for additional primary and mental health care staff.

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 medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[14] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The OIG noted that scores were similar to VHA's and asked executive leaders about their efforts to improve employee satisfaction. Each member provided a different perspective. The ADPCS emphasized effective communication and listening to mid-level leaders as the voice of front-line staff. The Director attributed the scores to an open-door policy and the professional obligation to escalate and resolve employee concerns. The COS also stressed the open-door policy and taking

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

[11] The patient aligned care team or PACT is a healthcare model used in the VA. Patients work "with health care professionals to plan for the whole-person care and life-long health and wellness." "Patient Care Services," Department of Veterans Affairs, accessed May 25, 2023, https://www.patientcare.va.gov/primarycare/PACT.asp.

[12] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Care in the Community," Department of Veterans Affairs, accessed May 23, 2023, https://www.va.gov/communitycare/.asp.

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

[14] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

all employee concerns seriously, adding that top-notch care for veterans cannot be achieved with dissatisfied employees. The Associate Director discussed talking with employees throughout the medical center and listening to their concerns as well as encouraging them to take the All Employee Survey to ensure maximum participation.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
W.G. (Bill) Hefner VA Medical Center	3.8	3.9	3.9

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

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

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. 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 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

The OIG noted that inpatient scores were lower than VHA averages for FYs 2020 and 2021, but increased and surpassed VHA scores in FY 2022. The ADPCS attributed it to a focus on the patient experience, the medical center environment, and the Salisbury Plan for Improving Customer Experience Committee. The ADPCS also explained that leaders, after recommendations from the committee, implemented inpatient changes such as renovating patient rooms, adding coffee machines, updating patient call systems, supplying patients with bedside electronic tablets, and increasing nursing visits to patient rooms.

The Director identified understaffing as a factor that reduced inpatient satisfaction. The Director reported a lengthy hiring process, up to 120 days, but described successful meetings with VISN human resources specialists to streamline this process.

Survey scores also indicated that patients' satisfaction with their primary care experiences increased over time but satisfaction with specialty care decreased. The ADPCS stated that

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

executive leaders communicated scores to team members for their awareness. The ADPCS also reported challenges increasing staffing levels as clinics expanded services to meet patient needs. The COS stressed the effect of understaffing on smaller services, such as pulmonary and sleep medicine, which created challenges with clinic access and resulted in appointment cancellations and unhappy patients.

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	66.7	69.7	66.3	68.9	70.3
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?* †	82.5	82.3	81.9	83.3	81.7	86.2
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?* †	84.8	84.7	83.3	83.1	83.1	82.9

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8, 2022).

**The response average is the percent of "Definitely yes" responses.*
†*The response average 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.[16] According to The Joint Commission's standards for leadership, a culture of safety and continual process

[16] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 19, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

improvements lead to safe, quality care for patients.[17] 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 and risk losing trust from patients and staff.[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 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.[22]

The OIG requested a list of adverse patient safety events that occurred during FY 2022 and reviewed events quality management staff provided. A patient safety manager indicated that staff entered adverse events into the Joint Patient Safety Reporting system, then patient safety managers and risk managers reviewed the events and reported them in daily huddles with executive leaders.[23] A patient safety manager described reviewing the event, referring to the

[17] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. 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 September 23, 2021, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

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

[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.

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

[21] VHA Directive 1004.08.

[22] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded this handbook and replaced it with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The new directive contains similar language regarding patient safety as the rescinded handbook.)

[23] "In 2018, the Veterans Health Administration began using the Joint Patient Safety Reporting system or (JPSR) which standardizes event capture and data management on medical errors and close calls/near misses for the Military and Veterans Health Systems." "VHA National Center for Patient Safety," Department of Veterans Affairs, accessed March 27, 2022, https://www.patientsafety.va.gov/about/faqs.asp.

patient safety directive and Joint Commission standards, and discussing the event with a risk manager to determine if a sentinel event occurred. Quality management staff reported relying on the patient safety guidebook and Joint Commission criteria, in addition to two-way communication between the risk managers and patient safety managers, to determine when an adverse event is a sentinel event.[24]

Quality management staff added that all sentinel events required disclosure, and the Director, COS, and quality management staff discussed each event, but the COS made the final determination on which type of disclosure was required. The ADPCS stated that providers carried out clinical disclosures, and the COS completed institutional disclosures, with the ADPCS participating if nursing staff were involved in the event.[25] The COS reported completing institutional disclosures within 72 hours of the event.

VHA implemented a culture change to move facilities toward becoming high reliability organizations. High reliability organizations strive to establish trust among leaders and staff and create an environment where employees feel safe to report adverse events and where leaders "focus on the why, not the who, when errors occur."[26] Quality management staff described being involved in the high reliability organization journey with support from executive leaders, notably the Director, who repeatedly told them to critique the process, not the people. These staff also mentioned the Director discussed high reliability organization values, or "pillars," daily, and the COS and ADPCS led related huddles or meetings.

The Director said the medical center was early on the high reliability organization journey and reported significant experience managing large healthcare systems that underwent cultural change. According to the COS, the Director had been working with the medical center's high reliability organization leadership coach to incorporate the principles into the facility's culture.

The OIG discussed the results of the prior comprehensive health inspection with the Chief, Office of Quality and Patient Safety; the Performance Improvement Coordinator; and patient safety and risk managers. The Chief, Office of Quality and Patient Safety acknowledged that one recommendation, related to staff training for prevention and management of disruptive behavior, remained open, explaining that in-person trainings were challenging to complete during the COVID-19 pandemic, but staff were now conducting them weekly to finish.

[24] VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[25] "Clinical disclosure of adverse events is a process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient's care." VHA Directive 1004.08.

[26] Richard A. Stone and Steven L. Lieberman, "VHA's Vision for a High Reliability Organization," *FORUM: Translating Research into Quality Healthcare for Veterans* (Summer 2020): 1–2, 7, https://www.hsrd.research.va.gov/publications/forum/summer20/Forum_summer2020.pdf.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[27] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[28] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[29]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[30] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[31]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[32] 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."[33] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[34]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed information for five deaths that occurred within 24 hours of inpatient admission during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG had no recommendations.

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

[28] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[29] VHA Directive 1100.16.

[30] VHA Handbook 1050.01; VHA Directive 1050.01.

[31] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[32] 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.

[33] VHA Directive 1190.

[34] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[35] 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."[36]

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

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.[39]

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.[40] 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

[35] 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.)

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Directive 1100.20.

one office under the COS. VHA also requires facilities to have credentialing and privileging managers and specialists with job duties that align under standard position descriptions.[41]

The OIG interviewed key managers and selected and reviewed the privileging folders of 26 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires providers with equivalent specialized training and similar privileges to evaluate LIPs on an ongoing basis.[42] The OIG found physician assistants or nurse practitioners completed Ongoing Professional Practice Evaluations for several physicians. The COS reported instructing service chiefs two years previously to discontinue this practice and implementing corrective actions to ensure similarly trained providers conduct all future LIP evaluations. Medical center staff demonstrated progress in improving the LIP evaluation process.

The OIG made no recommendations.

[41] 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.

[42] 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," May 18, 2021; VHA Directive 1100.21(1).

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 VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[43] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[44]

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 inspected 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]

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

- Dental clinic
- Emergency Department
- Intensive care unit (medical/surgical)
- Medical/surgical inpatient units (2-3 and 2-5)
- Mental health inpatient unit (8-1)
- Outer Banks Community Living Center

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[43] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[44] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[45] 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.) 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.)

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[46] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[47] The suicide rate for veterans was higher than for nonveteran adults during 2020.[48] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[49]

Due to the prevalence of suicide among at-risk veterans, VHA implemented 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.[50] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[51]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow-up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[52]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

---

[46] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[47] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, March 10, 2022.

[48] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[49] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[50] 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.)

[51] 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);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[52] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

VHA requires providers to complete Comprehensive Suicide Risk Evaluations following patients' positive suicide risk screens.[53] The OIG found that providers did not complete the evaluation for 50 (95% CI: 35 to 62) percent of patients who screened positive, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[54] Failure to evaluate patients for suicidal behavior could result in missed opportunities for providers to identify patients who are at imminent risk for suicide and intervene. The Suicide Prevention Program Manager explained that although the initial screen was positive in the identified cases, a provider completed an additional screen on the same day with a negative result and therefore did not complete the evaluation. The Suicide Prevention Program Manager reported educating providers that the additional screen with a negative result did not negate the need for an evaluation.

Recommendation 1

1. The Chief of Staff ensures providers complete a Comprehensive Suicide Risk Evaluation following a positive suicide risk screen.

Medical center concurred.

Target date for completion: May 31, 2024

Medical center response: The Suicide Prevention Program completed multidisciplinary education regarding the completion of the Comprehensive Suicide Risk Evaluation (CSRE) following a positive Columbia-Suicide Severity Rating Scale (C-SSRS). The Suicide Prevention Program Manager or designee will audit all electronic health records containing a positive Columbia-Suicide Risk Screen. Measure of compliance will use number of charts with a positive Columbia-Suicide Risk Screen as the denominator and the number of subsequently completed Comprehensive Suicide Risk Evaluations as the numerator. A minimum compliance of 90 percent will be achieved for six consecutive months. The Suicide Prevention Program Manager or designee will present the monthly audit numerator, denominator, and compliance percentage monthly to the Quality and Patient Safety Council.

VHA requires clinical staff to notify the suicide prevention team if a patient reports suicidal or other self-directed violent behaviors that occurred in the preceding 12 months during the

[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);" 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)."

[54] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Comprehensive Suicide Risk Evaluation.[55] The OIG found that clinical staff did not notify the suicide prevention team for one of four patients who reported suicidal behaviors. Failure to notify the suicide prevention team could delay interventions for patients at risk for suicide. The Suicide Prevention Program Manager stated the clinician may have believed the requirement to notify the suicide prevention team did not apply because the suicidal behavior occurred 11 months prior to the Comprehensive Suicide Risk Evaluation.

Recommendation 2

2. The Chief of Staff ensures clinical staff notify the suicide prevention team if patients report suicidal or other self-directed violent behaviors that occurred in the 12 months preceding the Comprehensive Suicide Risk Evaluation.

Medical center concurred.

Target date for completion: May 31, 2024

Medical center response: The Suicide Prevention Program Manager or designee will review and monitor all Comprehensive Suicide Risk Evaluations and Suicide Behavior and Overdose reports, monthly, for patients reporting suicidal or other self-directed violent behaviors within the last 12 months (denominator). The Suicide Prevention Coordinator or designee will verify the Suicide Prevention team was notified of any suicidal or other self-directed violent behaviors that occurred in the 12 months preceding the Comprehensive Suicide Risk Evaluation (numerator). A minimum compliance of 90 percent will be achieved for six consecutive months. The Suicide Prevention Program Manager or designee will present the audit numerator, denominator, and compliance percentage, monthly, to the Quality and Patient Safety Council.

VHA requires each medical center and very large community-based outpatient clinic to have one full-time suicide prevention coordinator to track and follow up with high-risk veterans and conduct community outreach activities.[56] The medical center had three community-based outpatient clinics that served at least 10,000 unique veterans annually. The OIG found that two of them shared one suicide prevention coordinator. The lack of a full-time coordinator for each site may delay patients' mental health interventions. The Suicide Prevention Program Manager reported asking for an additional full-time suicide prevention coordinator in FY 2022, but leaders denied the request.

[55] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting;" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting."

[56] VHA Handbook 1160.01; VHA Directive 1160.01; VHA Directive 1160.07.

Recommendation 3

3. The Chief of Staff ensures leaders appoint one full-time suicide prevention coordinator to each community-based outpatient clinic that serves at least 10,000 unique veterans annually.

Medical center concurred.

Target date for completion: December 1, 2023

Medical center response: An additional full-time suicide prevention coordinator position was approved through the facility Resource Management Committee (RMC) and is in the process of recruitment. The addition of the new full-time suicide prevention coordinator position ensures all community-based outpatient clinic locations now have a dedicated full-time suicide prevention coordinator.

VHA requires suicide prevention coordinators to use Suicide Prevention Program "national data systems, surveillance, and reports of suicide related events to facilitate monthly reporting to local mental health leadership and quality management."[57] The OIG found that the Suicide Prevention Program Manager reported suicide-related events for quarter four of FY 2022 to the Medical Executive Council, which included mental health leaders and quality management staff. The lack of monthly reporting on suicide-related events to mental health leaders and quality management staff could result in missed opportunities for them to identify needed program improvements. The Suicide Prevention Program Manager reported submitting quarterly reports to the Medical Executive Council and believed this was sufficient to meet VHA requirements. The Suicide Prevention Program Manager also reported attending the weekly Mental Health Manager/Coordinator meeting with mental health and social work leaders. However, the OIG noted that the weekly meeting minutes contained discussions solely related to suicide prevention staffing.

Recommendation 4

4. The Chief of Staff ensures the Suicide Prevention Program Manager reports suicide-related events monthly to mental health leaders and quality management staff.

[57] VHA Directive 1160.07.

Medical center concurred.

Target date for completion: December 1, 2023

Medical center response: Beginning March 16, 2023, all suicide-related events have been reported to mental health leaders and quality management staff at the monthly Quality and Patient Safety Council meeting. Measure of compliance will use number of suicide-related events as the denominator and the number of reported suicide events at Quality and Patient Safety Council as a numerator. A minimum compliance of 90 percent will be achieved for six consecutive months. The Suicide Prevention Program Manager or designee will present the monthly audit numerator, denominator, and compliance percentage, monthly, to the Quality and Patient Safety Council.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided four recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines four OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Chief of Staff. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• None
Mental Health: Suicide Prevention Initiatives	• Providers complete a Comprehensive Suicide Risk Evaluation following a positive suicide risk screen. • Clinical staff notify the suicide prevention team if patients report suicidal or other self-directed violent behaviors that occurred in the 12 months preceding the Comprehensive Suicide Risk Evaluation. • Leaders appoint one full-time suicide prevention coordinator to each community-based outpatient clinic that serves at least 10,000 unique veterans annually. • The Suicide Prevention Program Manager reports suicide-related events monthly to mental health leaders and quality management staff.

Appendix B: Medical Center Profile

The table below provides general background information for this high complexity (1b) affiliated medical center reporting to VISN 6.[1]

Table B.1. Profile for W.G. (Bill) Hefner VA Medical Center (659) (October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$842,890,502	$1,006,272,651	$1,057,189,382
Number of:			
• Unique patients	87,690	99,645	105,946
• Outpatient visits	924,113	1,086,139	1,043,455
• Unique employees§	2,899	3,014	2,984
Type and number of operating beds:			
• Community living center	124	124	124
• Domiciliary	56	56	15
• Medicine	30	32	39
• Mental health	46	46	46
• Residential rehabilitation	8	8	8
• Surgery	7	7	6
Average daily census:			
• Community living center	96	70	76
• Domiciliary	21	11	11
• Medicine	22	23	27
• Mental health	30	26	23
• Residential rehabilitation	4	4	5

[1] VHA medical facilities are classified according to a complexity model; a designation of "1b" indicates a facility with "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching program." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census, cont.:			
• Surgery	2	2	2

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, 2019, through September 30, 2020.*

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

‡October 1, 2021, through September 30, 2022.*

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 21, 2023

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subj: Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

To: Director, Office of Healthcare Inspections (54CH02)

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina.
2. I have reviewed and concur with the OIG recommendations and the action plans submitted by the W.G. (Bill) Hefner VA Medical Center. As we remain committed to ensuring our Veterans receive exceptional care, VISN 6 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.

(Original signed by:)

Paul S. Crews, MPH, FACHE

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: November 15, 2023

From: Interim Director, W.G. (Bill) Hefner VA Medical Center (659/00)

Subj: Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina.
2. I have reviewed and concur with the recommendations and will ensure the actions to correct the findings are completed and sustained as described in the responses. I appreciated the opportunity for this review as a continuing process to improve the care to our Veterans.

   (Original signed by:)

   Charles “Dave” Collins, MHA, MHRM, ACHE

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Rose Griggs, MSW, LCSW, Team Leader Barbara Miller, BSN, RN Team Leader Bruce Barnes Myra Brazell, MSW, LCSW Latoya Clark, RDN, MHA Miquita Hill-McCree, MSN, RN Frank Keslof, MHA, EMT Georgene Rea, MSW, LCSW Michael Tadych, MSW, FACHE Emorfia (Amy) Valkanos, RPh, BS
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Joanne Wasko, MSW, LCSW Elizabeth Whidden, MS, APRN Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 6: VA Mid-Atlantic Health Care Network
Director, W.G. (Bill) Hefner VA Medical Center (659)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Ted Budd, Thom Tillis
US House of Representatives: Alma Adams, Dan Bishop, Virginia Foxx, Richard Hudson, Jeff Jackson, Kathy Manning

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