US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Columbia VA Health Care System in South Carolina

CHIP Report | 23-00009-57 | January 25, 2024

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Figure 1. *Columbia VA Health Care System in South Carolina.*
Source: https://www.va.gov/columbia-south-carolina-health-care/locations/ (*accessed January 29, 2023*).

Abbreviations

ADPCNS	Associate Director of Patient Care and Nursing Services
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
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 Columbia VA Health Care System, which includes the Wm. Jennings Bryan Dorn VA Medical Center and multiple community-based outpatient clinics and a mobile clinic in South Carolina.[1] 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 Columbia VA Health Care System during the week of February 6, 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 healthcare system'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 Director in the Environment of Care and Mental Health areas of review. The number of recommendations should not be used as a gauge for the overall quality of care provided within this system. The

[1] The system includes the Columbia VA Mobile Clinic, which "offers primary care and other services to Veterans who are unable to visit" the healthcare system's locations. "Columbia VA Mobile Clinic," VA Columbia South Carolina health care, accessed January 29, 2023, https://www.va.gov/columbia-south-carolina-health-care/locations/columbia-va-mobile-clinic/.

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 throughout the report, and the recommendations are summarized in appendix A on page 21.

VA Comments

The Veterans Integrated Service Network Director and Acting Healthcare System 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 considers recommendation 2 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

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

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

To examine risks to patients and the organization, the OIG focused on core processes in the following 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 Columbia VA Health Care System includes the Wm. Jennings Bryan Dorn VA Medical Center and multiple outpatient clinics and a mobile clinic in South Carolina.[5] General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review during the week of February 6, 2023.[6] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[7] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

[5] The system includes the Columbia VA Mobile Clinic, which "offers primary care and other services to Veterans who are unable to visit" the healthcare system's locations. "Columbia VA Mobile Clinic," VA Columbia South Carolina health care, accessed January 29, 2023, https://www.va.gov/columbia-south-carolina-health-care/locations/columbia-va-mobile-clinic/.

[6] The OIG's last comprehensive healthcare inspection of the Columbia VA Health Care System occurred in March 2020. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in March 2022.

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

Results and Recommendations

Leadership and Organizational Risks

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

To assess this healthcare system's leadership and risks, the OIG considered 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 healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

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

At the time of the OIG inspection, the Director and Associate Director had been in their positions since 2017, and the ADPCNS was the most tenured, having served since 1999. The ADPCNS stated the executive team's stability was an asset that helped them lead the system through the COVID-19 pandemic.

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

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

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

To help assess executive leaders' engagement, the OIG interviewed the Chief of Staff, ADPCNS, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.[11]

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $842,649,654 had increased by about 1 percent compared to the previous year's budget of $832,232,174.[12] The ADPCNS reported leaders spent funding on staff overtime and pandemic retention incentives. The Associate Director stated that because of Workforce Management and Consulting Office recruitment and hiring delays, leaders returned some of the FY 2022 budget allocation, which resulted in their inability to hire additional employees.[13] This leader also reported using contracted employees to offset the staffing shortfalls.[14] The Associate Director said that because of an overall staff vacancy rate of 21 percent at the time of the OIG review, the hiring of additional staff was a critical need.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[15] 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.[16] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

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[11] At the time of the OIG interview, the Associate Director was covering for the Director, who was at a meeting off site most of the week.

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

[13] "WMC [Workforce Management & Consulting Office] provides VHA-wide leadership for workforce management functions including strategic human capital planning, executive recruitment and performance, labor management and labor relations, retention and recruitment, diversity and inclusion, operations and administration, as well as training and career development, and retention of a diverse, highly skilled, motivated, and effective workforce capable of accomplishing the Agency's mission." "Workforce Management and Consulting Office," PracticeLink, accessed February 22, 2023, https://www.practicelink.com/facility/Workforce-Management-and-Consulting-Office/Veterans-Health-Administration/.

[14] The Associate Director stated Workforce Management and Consulting Office is responsible for human resources at the healthcare system.

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

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

The survey results appeared to indicate staff agreed they could disclose suspected violations. The Associate Director reported system leaders promote whistleblower protection and also thoroughly review complaints and evaluate them for learning opportunities. The Associate Director also said staff can stop work processes to raise an issue at any time with no fear of reprisal, and leaders made system improvements after listening to staff concerns.

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
Columbia VA Health Care System	3.7	3.8	3.8

Source: VA All Employee Survey (accessed November 8, 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.[17] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

The inpatient scores appeared to indicate that most patients responded they would recommend the hospital to friends and family. The system's primary care and specialty care scores were lower than VHA averages from FYs 2020 through 2022. Although scores were lower than VHA averages, the results suggested most respondents were satisfied with the health care they received in the last 6 months. The ADPCNS stated nursing leaders used Press Ganey survey tools that provide patient feedback more rapidly than the Survey of Healthcare Experiences of Patients. The ADPCNS also said staff discussed patient scores in the clinics and during daily morning reports and veteran focus group meetings.[18] This leader added that staff reviewed scores to identify opportunities for improvement in areas such as scheduling, telephone response times,

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

[18] "The Press Ganey® Medical Practice Survey (Press Ganey® survey) is a patient-reported questionnaire commonly used to measure patient satisfaction with outpatient health care in the United States." Angela P. Presson et al., "Psychometric Properties of the Press Ganey® Outpatient Medical Practice Survey," *Health Qual Life Outcomes* 15, no. 1 (February 10, 2017): 32, https://doi.org/10.1186/s12955-017-0610-3.

and call abandonment rates (the rate at which calls are not answered before patients hang up). The ADPCNS reported making progress since staff began monitoring telephone response times and abandonment rates, which should improve overall primary and specialty care survey scores.

The Chief of Staff stated leaders added providers to the primary care service and began scheduling appointments more efficiently. For specialty care, the Chief of Staff explained leaders used inter-facility consults or community care to meet patient needs while hiring to replace two pulmonologists who had left.[19] To address the system's dental care capacity, the Chief of Staff reported leaders hired a dentist to assess consults and considered purchasing portable dental units to provide more care at the facility.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	67.5	69.7	69.3	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	82.1	81.9	77.1	81.7	79.7
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	80.9	83.3	81.2	83.1	79.3

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

*****The response average is the percent of "Definitely yes" responses.*

†The response average is the percent of "Very satisfied" and "Satisfied" responses.*

[19] Inter-facility consults are requests for services between two unique facilities. VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016. "VHA authorizes use of community providers for what is called an episode of care, or a course of treatment for a specific medical problem during a set time period." Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects*, October 2021.

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[20] According to The Joint Commission'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 and risk losing trust from patients and staff.[22]

"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)."[23] 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."[24] 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."[25] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[26]

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[20] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

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

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

[23] 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.

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

[25] VHA Directive 1004.08.

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

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred from October 1, 2021, through September 30, 2022, and reviewed the information staff provided. The Risk Manager stated that after an adverse event occurs, quality management staff immediately seek information about the incident from clinical providers, review the electronic health record, and consult with patient safety managers. The Risk Manager also said staff then compile recommendations and meet with the Chief of Staff, ADPCNS, and Quality Management Chief to determine whether to conduct an institutional disclosure. The OIG interviewed one of the two patient safety managers, who explained staff report patient safety events and the status of investigations in the executive leadership team morning report.[27] The manager further described tracking adverse events through the Joint Patient Safety Reporting system, reviewing the number of events reported and root cause analyses due each week, and meeting monthly with the Director to provide updates on adverse events and reviews.[28] The manager also discussed explaining the Joint Patient Safety Reporting system, as well as root cause analysis outcomes that brought system process improvements, at town hall forums.

The Quality Management Chief spoke about implementing VHA's HeRO Award for employees or volunteers who go above and beyond in patient care or patient safety, in addition to an *employee spotlight* in staff meetings to recognize outstanding efforts in patient safety. The ADPCNS stated patient safety managers created a Resiliency Response Team to provide support or referrals for staff who experience any type of distress following involvement in a patient-related adverse event.

In the OIG report *Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina,* the OIG issued recommendations that included improving institutional disclosure and root cause analysis processes.[29] At the time of this review, the Quality Management Chief reported having corrective action plans to address those open recommendations.[30]

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[27] "The PSM [Patient Safety Manager] is responsible for ensuring timely investigation of patient safety reports entered in JPSR [Joint Patient Safety Reporting system] at their facility." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance,* November 2021.

[28] "The Joint Patient Safety Reporting System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance.* A root cause analysis "is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01.

[29] VA OIG, *Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina*. Report No. 21-03203-239, September 27, 2022.

[30] "Recommendation 4. The Columbia VA Health Care System Director evaluates quality management practices that impede the timeliness of institutional disclosures, ensures current practices are in alignment with Veterans Health Administration policy, and takes action as warranted. Recommendation 5. The Columbia VA Health Care System Director ensures that root cause analyses are completed within the required 45-day time frame to promptly identify and address system vulnerabilities." VA OIG, *Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina*.

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.[31] 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.[32] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[33]

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.[34] 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.[35]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[36] 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."[37] 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.[38]

The OIG team interviewed key managers and reviewed relevant documents.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[33] VHA Directive 1100.16.

[34] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[36] 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.

[37] VHA Directive 1190.

[38] 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."[39] 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."[40]

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.[41] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[42]

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 an LIP 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.[43]

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.[44] 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 under the chief of staff. VHA also requires facilities to have credentialing and

[39] 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.)

[40] VHA Handbook 1100.19.

[41] VHA Handbook 1100.19.

[42] VHA Handbook 1100.19.

[43] VHA Handbook 1100.19.

[44] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[45]

The OIG interviewed key managers and selected and reviewed the privileging folders of 27 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires the FPPE process to "be defined in advance, using objective criteria accepted by the LIP, recommended by the service chief and ECMS [Executive Committee of the Medical Staff] as part of the privileging process, and approved by the VA medical facility Director."[46] The OIG found that service chiefs initiated the FPPE process for some LIPs, but their privileging folders lacked evidence they had accepted the criteria prior to start of the evaluation. When LIPs are not informed of the criteria used to evaluate their performance, they may not understand FPPE expectations. The Chief of Staff acknowledged lack of attention to detail in not following the standardized process for informing the LIPs about FPPE processes and criteria. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

[45] 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.

[46] VHA Handbook 1100.19; 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."[47] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[48]

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.[49]

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:

- Community living center (Congaree and Wateree)
- Emergency Department
- Intensive care unit (including beds for same-day patients)
- Medical/surgical inpatient unit (2 West)
- Mental health inpatient unit (Recovery West)
- Primary care clinic (White and Blue Team)

[47] 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.)

[48] 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.

[49] 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.)

Environment of Care Findings and Recommendations

The Joint Commission requires organizations to have written procedures for responding to utility system disruptions.[50] The OIG observed during a power outage that occurred while conducting rounds, staff continued to care for patients in the Freedom Primary Care Clinic—an area not on emergency backup power, with no lighting, no computer or phone access, and no written procedures for responding to a utility system disruption. When staff do not have procedures for utility system disruptions, they may inadvertently create an unsafe physical environment for patients, visitors, and other employees. The Chief of Safety and Emergency Management acknowledged staff continued to provide care without power and the system lacked a standard operating procedure for the situation. The Associate Director explained that, due to budget constraints, the clinic was not added to the emergency power grid because it did not provide overnight care. The Associate Director contended there was no standard operating procedure because it was impossible to plan for every potential scenario; however, the OIG concluded the Associate Director knew about this vulnerability but did not have a plan to address it.

Recommendation 1

1. The Director ensures staff have written procedures for responding to utility system disruptions.

Healthcare system concurred.

Target date for completion: April 30, 2024

Healthcare system response: A specific electrical system operational plan was developed by Chief of Safety and Emergency Management and published July 23, 2023. Operational Plan for Electrical Systems without emergency generators (Community Based Outpatient Clinics, building 120 Freedom Center, Hampton Street, Leesburg Road) was added to the facility Emergency Operations Plan [EOP] as section 18.2.1. This plan details a specific process for suspending services until power is restored. Compliance will be monitored during actual and exercise power outage episodes. Current exercise plan has a power outage scheduled for April 2024 in conjunction with the required triennial emergency power exercise which will test the newly developed EOP section 18.2.1 for building 120 Freedom Team, Hampton Street, and Leesburg Road.

The Joint Commission requires organizations to take action to minimize or eliminate identified safety and security risks in the physical environment.[51] The OIG found unattended and unsecured packaged patient care supplies including needles and used items, resulting in the presence of

[50] The Joint Commission, *Standards Manual*, E-dition, EC.02.05.01, January 1, 2023.

[51] The Joint Commission, *Standards Manual,* E-dition, EC.02.01.01, January 1, 2023.

biohazardous materials in the main medical center lobby, where laboratory blood draw stations had been set up.[52] Failure to secure biohazardous materials and medical supplies creates an unsafe environment for patients, visitors, and staff. The OIG observed this area could not be secured and was unstaffed after 2 p.m. The Chief of Safety and Emergency Management reported staff used the area each weekday until 2 p.m. due to space constraints in the main laboratory blood draw area. The Chief of Environmental Management Service attributed the failure to secure these items to an oversight.

Recommendation 2

2. The Director ensures staff identify, minimize, or eliminate safety and security risks in the physical environment.[53]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The unsecured items were immediately secured during the survey February 8, 2023. A process was implemented to transport the patient care supplies including needles and sharp container to the main lab when lobby stations were unattended and at the end of each day when service in this area closed. The facility ceased providing "Covid response" services in the lobby and returned to normal operations on April 3, 2023. Since the laboratory work was transitioned back to the main laboratory, the issue identified was eliminated and no monitoring was needed.

[52] Staff immediately secured needles and biohazardous materials when the OIG identified the deficiency.

[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.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[54] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[55] The suicide rate for veterans was higher than for nonveteran adults during 2020.[56] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[57]

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.[58] 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.[59]

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.[60]

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

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

[55] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

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

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

[58] 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.)

[59] 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.)

[60] VHA Directive 1160.07, *Suicide Prevention Program*. "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 designated staff to complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen. In ambulatory care settings, the screen and evaluation should occur on the same calendar day unless it is "not logistically feasible or clinically appropriate," such as situations where urgent or emergent care is needed.[61] The OIG estimated staff did not complete the evaluation for 30 (95% CI: 18 to 44) percent of patients with positive suicide risk screens.[62] Failure to evaluate patients following a positive screen poses a safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The Chief of Primary Care cited inadequate staffing as a reason for providers not consistently completing the evaluations as they had increased patient volume to cover for the vacancies. The Chief of Mental Health reported suicide prevention staff had recently implemented daily monitoring as a secondary check to ensure providers completed the evaluations.

Recommendation 3

3. The Director ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

[61] 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).

[62] 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.

Healthcare system concurred.

Target date for completion: July 30, 2024

Healthcare system response: Columbia VA Health Care System [CVAHCS] implemented warm handoff flow charts in each major clinical area and Community Based Outpatient Clinic (CBOC) to facilitate appropriate awareness and assessment via the Comprehensive Suicide Risk Evaluation (CSRE) of Veterans with positive suicide screens. Suicide Prevention runs a Veterans Integrated System Technology Architecture (VISTA) report daily to identify positive Columbia-Suicide Severity Rating Scale Screen (C-SSRS) and conducts a chart review for each Veteran. If a CSRE is not completed in the chart, Suicide Prevention Staff consult with relevant providers in order to facilitate assessment by the appropriate providers. Suicide Prevention conducts training on Risk Identification (Risk ID) processes and requirements at every New Provider Orientation the week following New Employee Orientation, in collaboration with Education Service, in order to make all new providers aware of requirements and their responsibilities. The Risk ID is the overall Office of Mental Health and Suicide Prevention program for improving suicide risk identification.

Overall compliance will be monitored via the National Power BI [Business Intelligence] Risk ID Dashboard: electronic Comprehensive Suicide Risk Evaluation (eCSRE) adherence rate. Suicide Prevention will submit reports to the Continuous Survey Readiness Committee until six consecutive months of 90 percent or greater compliance is achieved.

Since October 2022, CVAHCS has improved from 73% to 90% eCSRE adherence. We have seen two consecutive months at 90% or higher (October 2023: 91%, November 2023: 90%).

VHA requires clinical staff to notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.[63] The OIG found staff did not notify the suicide prevention team of two of four patients who reported suicidal behaviors. When the suicide prevention team does not receive notice of patients' suicidal behaviors, staff may delay further evaluation and mental health intervention. The Suicide Prevention Program Manager stated the suicide prevention team received notification of suicidal behaviors through automatic alerts in patients' electronic health records but was unable to provide evidence of the notifications to the OIG.

Recommendation 4

4. The Director ensures clinical staff notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.

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

Healthcare system concurred.

Target date for completion: July 30, 2024

Healthcare system response: The Associate Nurse Executives for Mental Health and Primary Care in collaboration with the Suicide Prevention Coordinator will develop and implement a re-education/training program for Mental Health and Primary Care Nursing on the Medical Center Policy 544-116-8, Identification, Assessment, and Management of Veterans at Risk for Suicidal Behavior. This will include flow charts for communication to the Licensed Independent Practitioner (warm hand off) for the next level of assessment when indicated by a positive screen. The education/training will include three case studies relevant for the settings of the Outpatient Mental Health General Clinic and three case studies relevant for the settings of Specialist and Primary Care settings.

Initial training will be completed by January 31, 2024, with follow-up refresher training as follows:

1. By January 31, 2024: Warm Handoff flow chart education and dissemination to all relevant staff, as well as the Columbia VA HCS Suicide Prevention SharePoint link where they are accessible any time.

2. By January 31, 2024, Risk ID Training for Nursing and Providers in Primary Care, Medicine/Specialty Care, and Mental Health.

3. By the end of Quarter 3 (June 2024), refresher training for Nursing and Providers in Primary Care, Medicine/Specialty Care, and Mental Health.

Overall compliance will be monitored via the National Power BI Risk ID Dashboard: electronic Comprehensive Suicide Risk Evaluation (eCSRE) adherence rate. Compliance monitoring for warm handoff specifically will be conducted daily by the Suicide Prevention Staff. Suicide Prevention Staff reviews positive C-SSRS daily via the VISTA report. They will review 90 percent of C-SSRS positives for compliance. Audit results will be reported monthly to the Continuous Survey Readiness Committee monthly until six consecutive months of 90 percent or greater compliance is achieved.

Numerator = number of audited reviews with communication to the Licensed Independent Provider after a positive Columbia-Suicide Severity Rating Scale Screen (C-SSRS).

Denominator = number of positive C-SSRS (90 percent of all positive C-SSRS).

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, 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 healthcare system. 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 Director. 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	• Staff have written procedures for responding to utility system disruptions. • Staff identify, minimize, or eliminate safety and security risks in the physical environment.
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen. • Clinical staff notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1b) affiliated healthcare system reporting to VISN 7.[1]

Table B.1. Profile for Columbia VA Health Care System (544)
(October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$715,464,190	$832,232,174	$842,649,654
Number of:			
• Unique patients	83,737	86,913	90,155
• Outpatient visits	1,118,878	1,194,611	1,105,449
• Unique employees§	2,571	2,579	2,478
Type and number of operating beds:			
• Community living center	94	94	94
• Medicine	69	69	69
• Mental health	20	22	22
• Surgery	21	21	21
Average daily census:			
• Community living center	51	16	21
• Medicine	36	37	31
• Mental health	10	11	12
• Surgery	3	3	3

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).*

[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 programs." 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.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 26, 2023

From: Director, VA Southeast Network (10N7)

Subj: Comprehensive Healthcare Inspection of the Columbia VA Health Care System in South Carolina

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

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

1. I have completed a full review of the Comprehensive Healthcare Inspection of the Columbia VA Health Care System in South Carolina draft report and concur with the findings.
2. I concur with the recommendations and action plan submitted by the Columbia VA Health Care System in South Carolina.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

David M. Walker, MD, MBA, FACHE

Appendix D: Acting Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: December 20, 2023

From: Acting Medical Center Director, Columbia VA Health Care System (544)

Subj: Comprehensive Healthcare Inspection of the Columbia VA Health Care System in South Carolina

To: Director, Southeast Network (10N7)

1. The Columbia VA Health Care System would like to thank the Office of the Inspector General Team for the thorough review and assessment during the Comprehensive Healthcare Inspection Program review.
2. I have reviewed each recommendation and concur with the findings, recommendations and submitted action plans. The plans have been carefully analyzed and will be implemented and monitored through satisfactory completion.

(Original signed by:)

Rebecca J. Strini, MHA, CLSSBB

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