US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Michael E. DeBakey VA Medical Center in Houston, Texas

CHIP Report | 22-00238-213 | September 22, 2023

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Figure 1. *Michael E. DeBakey VA Medical Center in Houston, Texas.*
Source: https://www.va.gov/houston-health-care/locations/.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Michael E. DeBakey VA Medical Center in Houston and multiple outpatient clinics in Texas. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

The OIG conducted an unannounced inspection of the Michael E. DeBakey VA Medical Center during the week of August 8, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this medical center and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement and issued three recommendations to the Director, Chief of Staff, and Deputy Director in the following areas of review: Leadership and Organizational Risks, Medical Staff Privileging, and Environment of Care. These opportunities for improvement are detailed throughout the report, and the recommendations are summarized in appendix A on page 21.

Conclusion

The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 24–25, 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.

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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 Michael E. DeBakey VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

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

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

Methodology

The Michael E. DeBakey VA Medical Center includes associated outpatient clinics in Texas. General information about the medical center can be found in appendix B.

The inspection team examined operations from February 6, 2017, through August 12, 2022, the last day of the unannounced multiday evaluation.[5] During the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

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

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

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

[5] The OIG's last Clinical Assessment Program review of the Michael E. DeBakey VA Medical Center occurred in February 2017. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in November 2020.

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

Results and Recommendations

Leadership and Organizational Risks

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

To assess this medical center's leadership and risks, the OIG considered several indicators:

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services, Deputy Director, and Associate Director. The Chief of Staff and Associate Director for Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for over one year, although the Director had served in the role since 2016 and several other team members had been in their positions for more than two years. To help assess the executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Associate Director for Patient Care Services, and Deputy Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

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

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

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

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2021 annual medical care budget of $1,524,141,940 had increased by over 14 percent compared to the previous year's budget of $1,336,616,200.[10] The Director reported the current FY funding allowed leaders to recruit and retain bedside nurses through monetary incentives. The Deputy Director stated the medical center needed to remain competitive with the local market and leaders were focused on retaining mental health staff as well as nurses. The Deputy Director also indicated the current budget was adequate but expressed concerns about predicting and managing costs for community care.[11]

Employee Satisfaction

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

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

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

[11] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed May 24, 2023, https://www.va.gov/communitycare/.

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

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

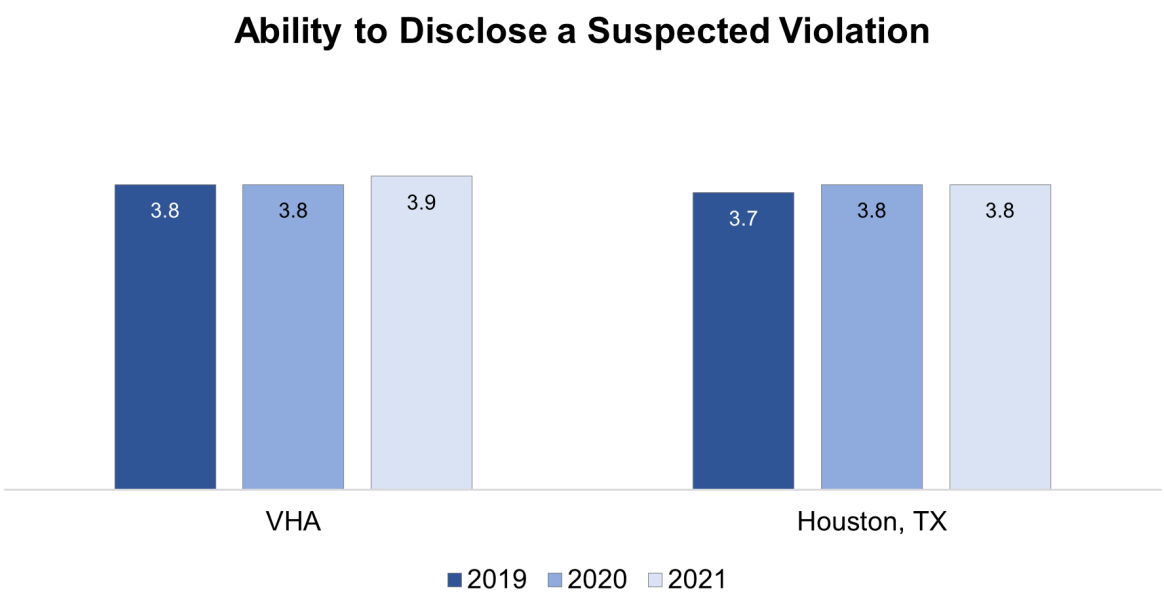

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed July 5, 2022).

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

Patient Experience

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

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

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

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

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

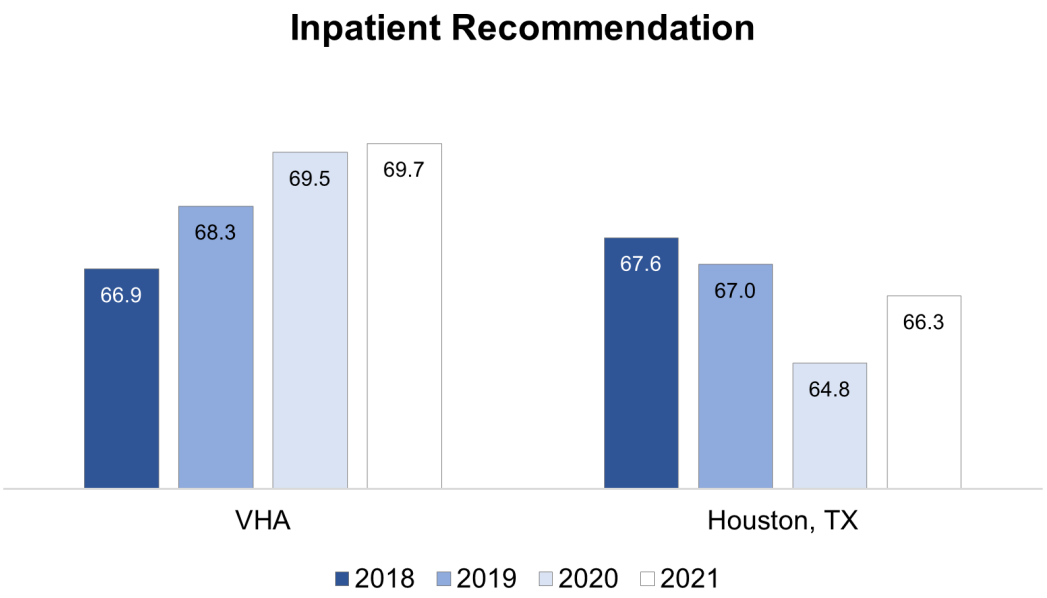

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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

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

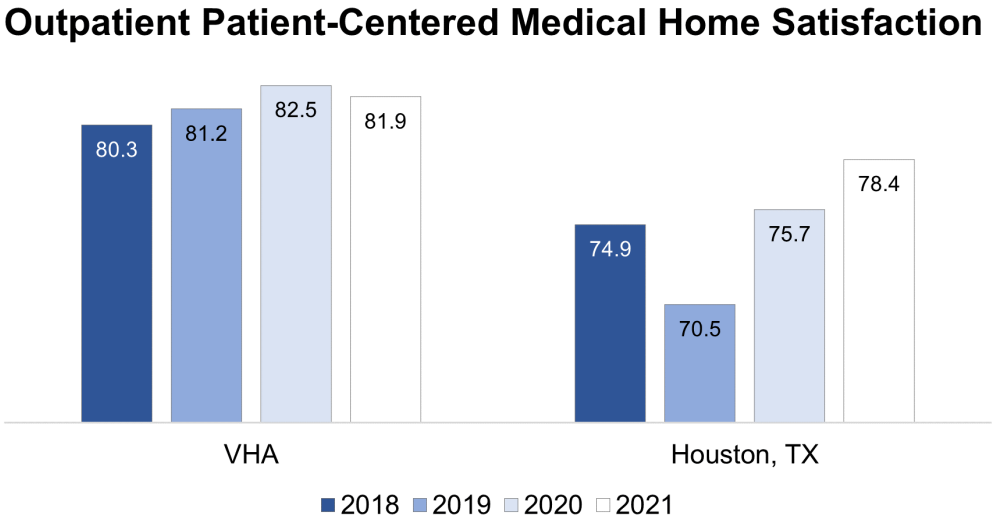

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

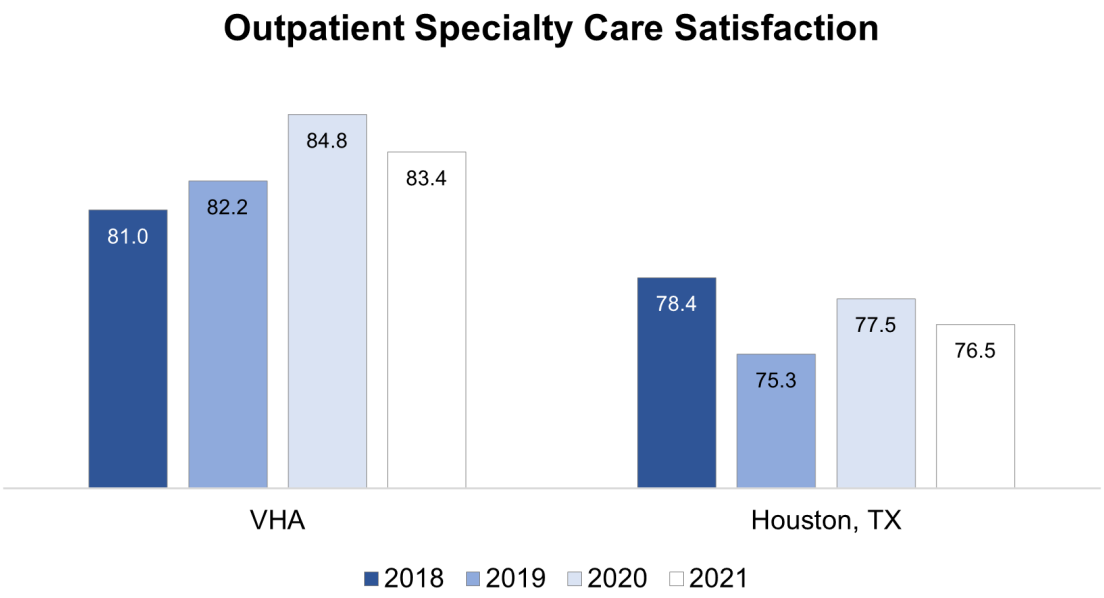

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

Identified Factors Related to Possible Lapses in Care and Medical Center Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] "A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[18] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and

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

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

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

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

The OIG requested sentinel events and institutional and large-scale disclosures that occurred since February 6, 2017, and reviewed the information staff provided through August 9, 2022. The Director reported being informed of adverse events by the Chief of Staff and Associate Director for Patient Care Services or through patient safety reports discussed at morning meetings. The Director stated the Director, Quality, Safety and Value determines when an adverse event qualifies as a sentinel event. The Director further explained that sentinel events require an issue brief and root cause analysis, and leaders decide whether to complete institutional disclosures based on guidance from the Office of General Counsel.[23]

Although the Director spoke knowledgeably about the adverse event reporting process, the OIG noted concerns related to leaders identifying and disclosing sentinel events. These concerns are discussed in greater detail below.

Leadership and Organizational Risks Findings and Recommendations

VHA requires leaders to conduct an institution disclosure when an adverse event causes or may cause the patient's death or serious injury.[24] The OIG found that leaders did not consistently conduct institutional disclosures for sentinel events that may have contributed to patients' deaths.

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

[20] VHA Directive 1004.08.

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

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

[23] A root cause analysis is a focused review to identify the actual system- and process-related contributing factors of the event. 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.)

[24] VHA Directive 1004.08.

Failure to disclose sentinel events may lead to missed opportunities for leaders to recognize safety trends and mitigate risks of future occurrences. Leaders attributed the deficiencies to lack of communication between Quality, Safety and Value service employees and the executive leadership team due to inconsistent staffing in the service, including vacancies in patient safety, risk management, and the service director positions. Additionally, the Director stated the COVID-19 pandemic contributed to short staffing in the Quality, Safety and Value service as employees were pulled from the service to help support pandemic efforts.

Recommendation 1

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

Medical center concurred.

Target date for completion: March 1, 2024

Medical center response: The Director evaluated and determined that there were no additional reasons for noncompliance. In September 2022, in order to ensure compliance, the facility, specifically the Quality and Patient Safety Service, initiated a crosswalk spreadsheet that is maintained and updated by [the] Patient Safety Program Director and Risk Managers monthly to track sentinel events and institutional disclosures. The Risk Manager will document leadership decisions regarding institutional disclosures on a separate institutional disclosure tracker. Potential sentinel/adverse events and institutional disclosures from multiple data sources are discussed by the appropriate stakeholders whenever necessary, most often during the weekly collaborative Clinical Concerns meeting between [the] Quality and Patient Safety Service, Chief of Staff's office, and the Clinical Practice Office (nursing). The Risk Manager will calculate the facility's compliance, where the numerator is the completed institutional disclosures, and the denominator is the number of sentinel events needing an institutional disclosure. These documents and the compliance percentage will be monitored by Director of Quality and Patient Safety. The Risk Manager will report the compliance percentage to the Quality and Patient Safety Committee on a quarterly basis until 90 percent compliance is sustained for six consecutive months.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[25] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[27]

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the medical center's committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the medical center's processes for conducting peer reviews of clinical care.[28] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[29] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[30]

Finally, the OIG assessed the medical center's culture of safety.[31] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

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

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

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

[27] VHA Directive 1100.16.

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

[29] VHA Directive 1190.

[30] VHA Directive 1190.

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

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[32] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[33]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[34] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[35]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[36]

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

[32] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Directive 1100.20.

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

The OIG interviewed key managers and reviewed the privileging folders of 30 medical staff members, including two solo or few practitioners, who had a Focused or Ongoing Professional Practice Evaluation.[39]

Medical Staff Privileging Findings and Recommendations

VHA required practitioners with similar training and privileges to evaluate the clinical practices of LIPs.[40] The OIG found that a similarly trained and privileged practitioner did not complete the Ongoing Professional Practice Evaluation of two solo or few LIPs. This could have resulted in LIPs providing care without a thorough evaluation of their practice, which could jeopardize patient safety. The Chief of Staff attributed the noncompliance to misunderstanding the requirement.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures practitioners with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.

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

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

[40] VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners." Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators." VHA now requires another practitioner with equivalent specialized training and similar privileges to complete the professional practice evaluation. VHA Directive 1100.21(1).

Medical center concurred.

Target date for completion: March 1, 2024

Medical center response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. The Credentialing and Privileging Manager identified all solo and two deep providers within the clinical services and re-educated senior clinical leaders of the requirement for Ongoing Professional Practice Evaluations to be completed by similarly trained and privileged clinicians. All solo and two deep providers' Ongoing Professional Practice Evaluations were identified and sent outside of the facility for appropriate completion by similarly privileged clinicians in the most recent Ongoing Professional Practice Evaluation cycle, confirmed with audits for compliance. The facility is actively utilizing the newly established VISN process for assignment and completion of outside reviews by similarly trained and privileged clinicians. The Credentialing and Privileging manager will monitor each Ongoing Professional Practice Evaluation cycle for outside reviewer compliance of solo and two deep providers. Compliance will be reported by the Credentialing and Privileging manager monthly to the Clinical Executive Board, Pentad and the Quality and Patient Safety Committee. Monitoring will occur until 90 percent compliance is met for six consecutive months.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[41] The physical environment of a healthcare organization must not only be functional but should also promote healing.

The purpose of this inspection was to determine whether staff maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG assessed compliance in selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[42]

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.[43] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times during emergencies and contribute to a safe healthcare environment.[44]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 15 patient care areas:

- Cardiac intensive care unit
- Community living center units (2C and 2D)

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[41] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded and replaced this directive with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.)

[42] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008.

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

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

- Emergency department
- Medical intensive care unit
- Medical/surgical inpatient units (3A and 4B)
- Mental health inpatient unit (6A)
- Mental health outpatient clinic (6B)
- Primary care clinic 3
- Prosthetics clinic
- Spinal cord injury inpatient unit
- Spinal cord injury outpatient clinic
- Surgical intensive care unit
- Urology clinic

Environment of Care Findings and Recommendations

VHA requires directors to follow Joint Commission standards for staff to monitor environmental conditions to ensure a clean and safe environment.[45] Joint Commission standards state hospital staff are to keep "furnishings and equipment safe and in good repair."[46] In 5 of 15 areas inspected, the OIG found damaged wheelchairs or furnishings with torn upholstery or worn-down finishes, making them no longer resistant to body fluid contamination and preventing effective disinfection. Additionally, the OIG noted monitor screens in all three intensive care units were covered with adhesive residue from medical tape and medication stickers, which also prevents effective cleaning and sanitizing.[47] These conditions present a potential risk of infection to patients and staff.

The Chief, Facilities Management stated that the deficiencies resulted from lack of oversight and attention to detail during daily inspections by individuals in charge of each space. The chief added that staff were unclear as to who should report or take corrective actions to address the issues. The chief also acknowledged the findings indicate a need to train staff on how to manage all aspects of the environment properly and consistently.

[45] VHA Directive 1608.

[46] The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, EP 26, January 1, 2022.

[47] The OIG found deficiencies in the primary care clinic; the inpatient mental health unit; the medical, surgical, and cardiac intensive care units; community living center units 2C and 2D; and medical/surgical inpatient unit 4B.

Recommendation 3

3. The Deputy Director evaluates and determines any additional reasons for noncompliance and ensures staff keep furnishings and equipment safe and in good repair.

Medical center concurred.

Target date for completion: March 1, 2024

Medical center response: The Deputy Director evaluated this recommendation and determined there are no additional reasons for noncompliance. Maintaining a clean, safe environment is the responsibility of all staff and facility processes are in place where staff can report broken furnishings and equipment problems. Each service line is required to submit a monthly Environment of Care checklist where the service line reviews environment of care requirements and checks for deficiencies for their specific areas. All deficiencies are submitted to [the] Interior Design Service, Facilities Management Service, and Environmental Management Service and discussed through appropriate forums. The Facilities Management Service, Interior Design Service, and Environmental Management Service will review the submitted Environment of Care checklists to determine whether the deficiencies reported by the service lines areas are corrected within the appropriate time frame. The numerator is the total number of corrected deficiencies identified from the Environment of Care checklists and the denominator is the total number of environment of care deficiencies submitted by the care [service] lines. These documents and the percent compliance will be monitored by the respective areas. [The] Facilities Management Service, Interior Design Service, and Environmental Management Service will report the numerator, denominator, and compliance percentage to the Deputy Director through the Environment of Care committee on a quarterly basis until 90 percent compliance is sustained for six consecutive months.

Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives

Suicide prevention remains the top clinical priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides among U.S. adults."[48] Additionally, "among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019."[49]

VHA implemented various evidence-based approaches to reduce veteran suicides, including a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[50] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from emergency departments or urgent care centers and receive "structured post-discharge follow-up to facilitate engagement in outpatient mental health care."[51] The OIG assessed the medical center for its adherence to staff completion of suicide safety plans prior to patients' discharge from the emergency department or urgent care center and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 44 randomly selected patients who were seen in the emergency department or urgent care center from December 31, 2020, through August 1, 2021.

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

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

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

Mental Health Findings and Recommendations

The OIG made no recommendations.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• Leaders conduct institutional disclosures for applicable sentinel events.
Quality, Safety, and Value	• None
Medical Staff Privileging	• Practitioners with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.
Environment of Care	• Staff keep furnishings and equipment safe and in good repair.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• None

Appendix B: Medical Center Profile

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

Table B.1. Profile for Michael E. DeBakey VA Medical Center (580) (October 1, 2018, through September 30, 2021)

Profile Element	Medical Center Data FY 2019*	Medical Center Data FY 2020†	Medical Center Data FY 2021‡
Total medical care budget	$1,184,676,413	$1,336,616,200	$1,524,141,940
Number of:			
• Unique patients	117,052	113,610	122,514
• Outpatient visits	1,499,717	1,378,157	1,578,020
• Unique employees§	4,819	4,872	4,972
Type and number of operating beds:			
• Community living center	141	141	141
• Medicine	164	164	164
• Mental health	73	73	73
• Neurology	14	14	14
• Rehabilitation medicine	18	18	18
• Spinal cord	40	40	35
• Surgery	88	88	88
Average daily census:			
• Community living center	124	140	116
• Medicine	109	107	132
• Mental health	48	36	23
• Neurology	7	4	7
• Rehabilitation medicine	7	5	4
• Spinal cord	31	33	30

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

Profile Element	Medical Center Data FY 2019*	Medical Center Data FY 2020†	Medical Center Data FY 2021‡
Average daily census (cont.):			
• Surgery	47	38	38

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 29, 2023

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

Subj: Comprehensive Healthcare Inspection of the Michael E. DeBakey VA Medical Center in Houston, Texas

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

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

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

(Original signed by:)

Skye McDougall, PhD
VISN 16 Network Director

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: August 28, 2023

From: Director, Michael E. DeBakey VA Medical Center (580)

Subj: Comprehensive Healthcare Inspection of the Michael E. DeBakey VA Medical Center (MEDVAMC) in Houston, Texas

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

1. Thank you for conducting the Comprehensive Healthcare Inspection (OIG) review during the week of August 8, 2022, at MEDVAMC.
2. The recommendations have been reviewed. MEDVAMC concurs with all recommendations.
3. A plan of action for each of the three recommendations is attached. The three plans of action have been carefully analyzed and will be implemented and monitored through satisfactory completion.
4. I have reviewed the document and concur with the response as submitted.

(Original signed by:)

Mr. Francisco Vazquez, MBA
Director

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