US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont

CHIP Report | 23-00015-86 | February 28, 2024

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Figure 1. *White River Junction VA Medical Center in Vermont.*
Source: https://www.va.gov/white-river-junction-health-care/locations/white-river-junction-va-medical-center/ (*accessed September 13, 2023*).

Abbreviations

ADPC	Associate Director, Patient Care
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
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 White River Junction VA Medical Center and associated outpatient clinics in New Hampshire and Vermont. 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 White River Junction VA Medical Center during the week of March 13, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued five recommendations to the Medical Center Director and Chief of Staff in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered

with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 21.

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 23–24, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH JR., M.D.
Assistant Inspector General
for Healthcare Inspections

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

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

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

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

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

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014), 13, https://doi.org/10.1136/bmjopen-2014-005055.

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

[4] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The White River Junction VA Medical Center includes multiple outpatient clinics in New Hampshire and Vermont. General information about the medical center can be found in appendix B.

The OIG inspected the White River Junction VA Medical Center during the week of March 13, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

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

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

[5] The OIG's last comprehensive healthcare inspection of the White River Junction VA Medical Center occurred in January 2021. The Joint Commission performed a hospital accreditation review in April 2022.

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

Results and Recommendations

Leadership and Organizational Risks

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

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

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

Executive Leadership Position Stability and Engagement

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

At the time of the OIG inspection, the executive team had worked together for approximately two months, since the acting Medical Center Director (whose current permanent position was the Associate Director, Operations) and the acting Associate Director, Operations (detailed from

[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.

another facility) had begun serving in their roles.[10] The Chief of Staff was assigned in November 2019, and the ADPC in September 2022.

To help assess executive leaders' engagement, the OIG interviewed the acting Medical Center Director; Chief of Staff; ADPC; and acting Associate Director, Operations regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $347,750,625 had increased by approximately 1 percent compared to the previous year's budget of $345,055,445.[11] Leaders shared that the funding was inadequate and projected a $20 million deficit in FY 2023. The acting Medical Center Director and acting Associate Director, Operations added that the medical center did not receive as much funding as other similar-complexity facilities, and leaders had been working to determine if they were adequately documenting workload. The ADPC said the budget supported safe nurse staffing levels.

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 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.[13] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The medical center's scores were similar to VHA's for all three years. The acting Medical Center Director reported receiving emails or messages through an anonymous portal from staff who feel safe reporting facility issues. The Chief of Staff stated staff have a culture of teamwork and collaboration and are mission driven to report safety concerns.

[10] The Medical Center Director was temporarily assigned to the VA Connecticut Healthcare System from January 3 through May 3, 2023, and the assigned Associate Director, Operations was the acting Medical Center Director during that time. The acting Associate Director, Operations was temporarily assigned on January 15, 2023.

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

[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.

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
White River Junction VA Medical Center	3.9	4.0	3.9

Source: VA All Employee Survey (accessed November 15, 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.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

The medical center's inpatient, primary care, and specialty care scores were consistently higher than VHA's during this period. Inpatient and specialty care scores declined over time, which indicated patient satisfaction with their healthcare experiences decreased. However, scores also indicated that patient satisfaction with their primary care improved. The ADPC reported that primary care staff did not turn away patients wanting same-day appointments and allotted time into the provider's schedule so patients could be seen.

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

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	83.2	69.7	78.3	68.9	76.0
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	89.1	81.9	89.1	81.7	90.3
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	92.4	83.3	90.2	83.1	86.6

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.*

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.[15] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[16] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[15] 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/.

[16] The Joint Commission, *Standards Manual*, E-dition, July 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.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[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 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.[21]

The Chief of Staff reported that staff track sentinel events in the Joint Patient Safety Reporting system.[22] In addition, this leader described being notified of adverse events through the Risk Manager, peer reviews, and the Patient Safety Committee.[23] The OIG noted there were no sentinel events resulting in death at the medical center that required an institutional disclosure.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[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.

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

[20] VHA Directive 1004.08.

[21] 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.)

[22] The Joint Patient Safety Reporting system is a database used for staff to report patient safety events. VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[23] 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.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[24] 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.[25] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[26]

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.[27] 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.[28]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care. 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 assessments of care" that consistently contribute to quality management efforts at the individual provider level.[30]

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

Quality, Safety, and Value Findings and Recommendations

VHA requires staff to complete a minimum of eight patient safety analyses each year. These can include a root cause analysis, which is a focused review to identify the underlying factors of a patient safety event, and an aggregated review to analyze similar events.[31] The OIG found staff completed three patient safety analyses in FY 2022. Failing to complete all required analyses could have led to missed opportunities for staff to identify prevention strategies for adverse

[24] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[25] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.
[26] VHA Directive 1100.16.
[27] VHA Handbook 1050.01; VHA Directive 1050.01.
[28] The Joint Commission, *Standards Manual,* E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.
[29] VHA Directive 1190.
[30] VHA Directive 1190.
[31] VHA Handbook 1050.01; VHA Directive 1050.01.

events. The acting Chief, Quality and Patient Safety reported being unable to speak about events that occurred prior to assuming the position.

Recommendation 1

1. The Medical Center Director ensures staff complete a minimum of eight patient safety analyses each year.

Medical center concurred.

Target date for completion: December 31, 2024

Medical center response: The White River Junction Medical Center values patient safety and is committed to completion of the required number of patient safety analyses. A minimum of eight patient safety analyses will be completed and submitted annually and will be tracked by the Patient Safety Manager. Reporting of this tracking will be presented monthly at the Quality and Patient Safety Committee meeting by the Patient Safety Manager, at which the Medical Center Director attends, until a total of eight patient safety analyses are completed in 2024.

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 (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 (OPPE) 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 under the chief of staff. VHA also requires facilities to have credentialing and

[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.

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

The OIG interviewed key managers and selected and reviewed privileging folders of 25 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires FPPE criteria to be defined in advance, "using objective criteria accepted by the LIP."[39] The OIG found that privileging folders did not consistently have evidence the LIPs accepted FPPE criteria before service chiefs initiated the process. LIPs could misunderstand FPPE expectations when service chiefs do not inform them of criteria in advance. The Chief of Staff reported believing service chiefs verbally discussed the criteria before initiating the FPPE process. 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.

VHA also requires practitioners with equivalent specialized training and similar privileges to complete LIPs' professional practice evaluations.[40] The OIG did not receive all requested privileging information and therefore was unable to determine that similarly trained and privileged providers completed some of the professional practice evaluations. The lack of a specialty-focused competency evaluation could adversely affect quality of care and patient safety. The Chief of Staff could not explain why staff did not provide reviewers' privileges to the OIG.

Recommendation 2

2. The Chief of Staff ensures practitioners with equivalent specialized training and similar privileges complete Focused and Ongoing Professional Practice Evaluations.

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

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

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

Medical center concurred.

Target date for completion: December 1, 2024

Medical center response: To ensure compliance with this recommendation, the Credentialing and Privileging Manager will continue to track and monitor all completed Focused Professional Practice Evaluations for review by practitioners with equivalent specialized training and similar privileges, and reporting of this tracking will be presented monthly at the Quality and Patient Safety Committee meeting by the Credentialing and Privileging Manager, at which the Chief of Staff attends, until we have demonstrated 90 percent compliance for six consecutive months. The numerator will be the number of completed Focused Professional Practice Evaluations by practitioners with equivalent specialized training and similar privileges, and the denominator will be the total number of completed Focused Professional Practice Evaluations.

Ongoing Professional Practice Evaluations are completed in six-month cycles at the White River Junction Medical Center. To ensure compliance with this recommendation, the Credentialing and Privileging Manager will continue to track and monitor all completed Ongoing Professional Practice Evaluations for completion by practitioners with equivalent specialized training and similar privileges. The Credentialing and Privileging Manager will report this tracking every six months at the Quality and Patient Safety Committee meeting, at which the Chief of Staff attends, until we have achieved 90 percent compliance for six consecutive months. The numerator will be the number of completed Ongoing Professional Practice Evaluations by practitioners with equivalent specialized training and similar privileges and the denominator will be the total number of Ongoing Professional Practice Evaluations due for completion.

For both Focused and Ongoing Professional Practice Evaluations, the Credentialing and Privileging Manager will track provider privileges, peer review, and reviewer privileges, and will present this information monthly to the Quality and Patient Safety Committee.

VHA requires service chiefs to complete OPPEs for every privileged LIP on a regular basis.[41] The OIG found that service chiefs did not regularly complete OPPEs. Incomplete OPPEs may result in LIPs providing patient care without a thorough competency evaluation, potentially jeopardizing patient safety. The Chief of Staff reported being unaware of the deficiencies and provided no reason for the incomplete OPPEs.

Recommendation 3

3. The Chief of Staff ensures service chiefs complete licensed independent practitioners' Ongoing Professional Practice Evaluations on a regular basis.

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

Medical center concurred.

Target date for completion: December 1, 2024

Medical center response: To ensure compliance with this recommendation, the Credentialing and Privileging Manager will track and monitor completion of Ongoing Professional Practice Evaluations for licensed independent practitioners and report this tracking every six months at the Quality and Patient Safety Committee meeting, at which the Chief of Staff attends, until we have achieved 90 percent compliance for six consecutive months. The numerator will be the number of licensed independent practitioners' Ongoing Professional Practice Evaluations completed every six months, and the denominator will be the total number of licensed independent practitioners requiring Ongoing Professional Practice Evaluations every six months. The entire Ongoing Professional Practice Evaluation packet (all supporting documents included within the practitioner profile) will be reviewed at the Clinical Executive Board, and those minutes will include documented review of the Ongoing Professional Practice Evaluation packet. The Credentialing and Privileging Manager will review and track Ongoing Professional Practice Evaluation service-specific forms, peer review, reviewer privileges, and Clinical Executive Board minutes, and will present this information monthly to the Quality and Patient Safety Committee.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct inspections and track issues until they are resolved.[42] The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[43] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[44]

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

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

- Emergency Department
- Inpatient Unit (south)
- Intensive Care Unit
- Mental health inpatient unit
- Primary care clinic

Environment of Care Findings and Recommendations

VHA requires staff to ensure medical supplies are "not contaminated, damaged, expired, or recalled."[46] The OIG observed expired medical supplies in three of five patient care areas

[42] 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.)

[43] VHA Directive 1608.

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

[45] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

[46] VHA Directive 1761.

inspected.[47] The use of expired supplies pose a risk of infection to patients. The Infection Control Nurse Manager reported believing staff likely overlooked the supplies due to infrequent use. Because staff corrected the deficiency during the inspection, the OIG made no recommendation.

[47] The OIG found deficiencies in the Inpatient Unit (south), Intensive Care Unit, and primary care clinic.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[48] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[49] The suicide rate for veterans was higher than for nonveteran adults during 2020.[50] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[51]

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.[52] 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.[53]

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.[54]

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

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

[49] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed February 14, 2023.

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

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

[52] 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.)

[53] 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.)

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

Mental Health Findings and Recommendations

VHA requires the suicide prevention coordinator to report suicide-related events monthly to "local mental health leadership and quality management."[55] The OIG found the suicide prevention coordinators did not report suicide-related events monthly. Without suicide-related event reporting at the local level, the mental health and quality management teams could miss opportunities to monitor at-risk patients and provide timely interventions. The Deputy Chief, Mental Health and both suicide prevention coordinators explained the coordinators frequently reported verbally to mental health leaders over the past year and a half but acknowledged there was no evidence of reporting each month. Additionally, all three staff said that during the period reviewed, they were unaware of the monthly reporting requirement to quality management staff. The acting Chief, Quality and Patient Safety reported being unable to speak about events prior to assuming the position and added that leaders began focusing on implementing new processes, including the monthly suicide-related reporting requirement, in the fourth quarter of FY 2022.

Recommendation 4

4. The Medical Center Director ensures the suicide prevention coordinators report suicide-related events monthly to mental health leaders and quality management staff.

Medical center concurred.

Target date for completion: September 1, 2024

Medical center response: The Suicide Prevention Coordinators created a monthly workgroup, the Suicide and Behavior Overdose Reports, to report suicide-related events to mental health leaders and quality management staff.

A monthly audit of the workgroup's minutes will be completed by the Suicide Prevention Coordinators to achieve a minimum of 90 percent compliance for six consecutive months. The numerator will be the number of months with documented workgroup meeting minutes that include reporting of suicide related events, and the denominator will be the number of months audited. The Suicide Prevention Coordinator/designee will present the audit findings, to include the numerator, denominator, and compliance percentage, monthly at the Quality and Patient Safety Committee meeting, for which the Medical Center Director, Chief of Quality and Patient Safety, and Chief of Mental Health attend meetings.

VHA requires providers to complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen. VHA also states that providers should complete the

[55] VHA Directive 1160.07.

evaluation on the same day as a positive screen in all ambulatory care settings.[56] The OIG estimated that providers did not complete the evaluations on the same calendar day for 28 (95% CI: 16 to 42) percent of patients with positive screens, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[57] Failure to complete the evaluation on the same day poses a safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The Chief, Primary Care reported believing providers gathered the evaluation information during the patient's initial appointment but documented it later, likely because of competing clinical demands or inexperience with evaluation requirements due to infrequent positive screenings.

Recommendation 5

5. The Medical Center Director ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

[56] 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)."

[57] 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.

Medical center concurred.

Target date for completion: September 1, 2024

Medical center response: The Suicide Prevention team twice daily reviews a report provided by the Veterans Integrated Service Network Informatics of patients with a positive suicide risk screen. The Suicide Prevention Coordinator/designee reviews patient records that have a positive screen and follows up with the treating provider to ensure the Comprehensive Suicide Risk Evaluation is completed on the same day as the positive screen.

The Suicide Prevention Coordinators will continue to track and monitor for completed Comprehensive Suicide Risk Evaluations on the same day for all patients with a positive suicide screen in all ambulatory care settings, and reporting of this tracking will be presented quarterly at the Quality and Patient Safety Committee meeting by the Suicide Prevention Coordinator/designee, at which the Medical Center Director attends. Assessment of compliance will be measured on a quarterly basis until we have demonstrated 90 percent compliance for two consecutive quarters. The numerator will be the number of completed Comprehensive Suicide Risk Evaluations on the same day for patients with a positive suicide screen in all ambulatory care settings, and the denominator will be the total number of patients with a positive suicide screen within all ambulatory care settings.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• Staff complete a minimum of eight patient safety analyses each year.
Medical Staff Privileging	• Practitioners with equivalent specialized training and similar privileges complete Focused and Ongoing Professional Practice Evaluations. • Service chiefs complete licensed independent practitioners' Ongoing Professional Practice Evaluations on a regular basis.
Environment of Care	• None
Mental Health: Suicide Prevention Initiatives	• The suicide prevention coordinators report suicide-related events monthly to mental health leaders and quality management staff. • Providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

Appendix B: Medical Center Profile

The table below provides general background information for this medium complexity (2) affiliated medical center reporting to VISN 1.[1]

Table B.1. Profile for White River Junction VA Medical Center (405) (October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$325,133,611	$345,055,445	$347,750,625
Number of:			
• Unique patients	24,183	26,212	25,830
• Outpatient visits	271,062	301,628	289,768
• Unique employees§	1,037	1,065	1,025
Type and number of operating beds:			
• Domiciliary	14	14	14
• Medicine	34	34	30
• Mental health	12	12	12
• Surgery	9	9	7
Average daily census:			
• Domiciliary	6	5	8
• Medicine	17	18	16
• Mental health	5	5	5
• Surgery	3	4	4

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

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

**October 1, 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 "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 31, 2024

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont

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

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

Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont.

I have reviewed and concur with the recommendations, findings, and action plans set forth in this report.

(Original signed by:)

Ryan Lilly, MPA
Network Director
VA New England Healthcare System

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: January 31, 2024

From: Director, White River Junction VA Medical Center (405)

Subj: Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont

To: Director, VA New England Healthcare System (10N1)

Thank you for the opportunity to review and provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont.

I have reviewed and concur with the findings and recommendations. I have provided detailed action plans completed after our Comprehensive Healthcare Inspection to correct these findings.

I appreciate the Office of Inspector General's partnership in our continuous improvement efforts.

(Original signed by:)

Brett Rusch, MD
Director
White River Junction VA Medical Center

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Tamara White, BSN, RN, Team Leader Kelley Brendler-Hall, MSN, RN Latoya Clark, MHA, RD Catherine McNeal-Jones, MSN, RN Judy Montano, MS
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Angela Enlow, PhD Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Jarvis Yu, MS

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