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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System in Montgomery

CHIP Report | 23-00106-94 | March 12, 2024

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Figure 1. *Central Alabama VA Medical Center-Montgomery of the Central Alabama Veterans Health Care System.*

Source: https://www.va.gov/locations/central-alabama-va-medical-center-montgomery/ (*accessed January 22, 2024*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
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 Central Alabama Veterans Health Care System, which includes the Central Alabama VA Medical Center-Montgomery, Central Alabama VA Medical Center-Tuskegee, and multiple outpatient clinics in Alabama and Georgia. 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 Central Alabama Veterans Health Care System during the week of May 8, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued two recommendations to the Chief of Staff in the Mental Health area of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. 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 18.

VA Comments

The Veterans Integrated Service Network Director and acting healthcare system Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 21–22, 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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Assistant Inspector General
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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 Central Alabama Veterans Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

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

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

Methodology

The Central Alabama Veterans Health Care System includes the Central Alabama VA Medical Center-Montgomery, Central Alabama VA Medical Center-Tuskegee, and multiple outpatient clinics in Alabama and Georgia. General information about the healthcare system can be found in appendix B.

The OIG initiated an unannounced inspection of the Central Alabama Veterans Health Care System the week of May 8, 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 healthcare system leaders complete corrective actions. The acting Director's responses to the report recommendations appear within the associated topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the Central Alabama Veterans Health Care System occurred in February 2020. The Joint Commission performed hospital, behavioral health care and human services, home care, and laboratory accreditation reviews in March and 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 healthcare system's leadership and risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director, Deputy Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director.[10] The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for about eleven months, except for the acting Associate Director. The newest permanent member of the leadership team, the Chief of Staff, was assigned in June 2022. The most tenured leader, the Deputy Director, had served in the role since November 2017.

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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.

[10] An acting Associate Director was appointed to serve until the position could be permanently filled.

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

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $524,568,057 had increased by almost 16 percent compared to the previous year's budget of $453,589,449.[11] The Director reported using funds to remodel an existing building at the Tuskegee campus and purchase the Brillians system to facilitate more efficient charting in the electronic health record system and Vocera devices to improve rapid communication among staff.[12] The Chief of Staff spoke about spending funds on the Dental Department for staff (dentists) and equipment (chair-side imaging machines and image storage devices). The ADPCS said leaders also used money to hire temporary nursing assistants to screen for COVID-19 and help transport patients to and from appointments. The ADPCS further discussed using funds to purchase care in the community for dental and neurology services, as well as for COVID-19 testing supplies and personal protective equipment for staff.[13]

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[14] 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.[15] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

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

[12] "Brillians is a clinical decision support system (CDSS) that pulls specific information from [the] Computerized Patient Record System (CPRS), analyzes the information, and alerts the provider regarding issues that require the provider`s attention at the point of care." "VA Technical Reference Model v 23.12," Department of Veterans Affairs, accessed January 23, 2024, https://www.oit.va.gov/Services/TRM/ToolPage.aspx?tid=7557. Vocera helps clinicians and staff communicate using wearable devices that allow voice, text, and alarm notifications about patients, care teams, and events. "VA Technical Reference Model v 23.12," Department of Veterans Affairs, accessed January 22, 2024, https://www.oit.va.gov/Services/TRM/ToolPage.aspx?tid=15309.

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

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

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

The healthcare system's scores were slightly below VHA averages all three years. The Director attributed the results to staff likely still being angry about the merger of the two campuses into one healthcare system 26 years ago. The Director further stated staff believed leaders had shifted many of the services from the Tuskegee campus to the Montgomery campus, which made them feel the Tuskegee campus was not important. The Chief of Staff and ADPCS said the leadership team's transparency and commitment to psychological safety likely helped scores improve in FY 2021.

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
Central Alabama Veterans Health Care System	3.6	3.7	3.7

Source: VA All Employee Survey (accessed November 28, 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.[16] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

The healthcare system's inpatient scores were lower than VHA averages, indicating patients at this system were less satisfied with their inpatient care compared to VHA patients nationally. The Director attributed the scores to provider and nurse staffing challenges, although leaders had worked to increase full-time provider staffing levels. The Chief of Staff said that when patients saw inconsistent staff, they lost confidence in the care they received. To improve patient satisfaction, the Chief of Staff reported strengthening interdisciplinary teams to provide more consistent interactions and information to patients. Additionally, the Chief of Staff said that as a personal touch, a member of the interdisciplinary team sends a thank-you card (for choosing VA for their care) to each patient after discharge with a reminder of their follow-up treatment plan and care team members' names.

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

Survey scores also indicated that patients' satisfaction with their primary and specialty care experiences generally improved. The Director listed several actions taken to improve satisfaction such as increasing affiliations with more medical schools; adding extra support staff in primary care; and hiring additional specialty providers in nephrology, urology, and gastroenterology. All interviewed leaders identified opportunities to improve the customer experience in primary and specialty care. Each described implementation of the *Commit to Sit* initiative to allow more time for patients to get to know their providers.[17]

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	53.1	69.7	54.8	68.9	51.1
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	67.9	81.9	71.0	81.7	75.2
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†*	84.8	75.2	83.3	77.1	83.1	76.1

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.*

[17] Irina Kleytman and Marianne Youssef, "Commit to Sit to Improve Patient Satisfaction," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 50, no. 5 (October 2021): S2, https://doi.org/10.1016/j.jogn.2021.08.015.

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[18] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[19] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[20]

"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)."[21] 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."[22] 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."[23] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[24]

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

[19] 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.

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

[21] 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.

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

[23] VHA Directive 1004.08.

[24] 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.)

When asked about the patient safety processes, the Director described sharing the importance of reporting safety events during new employee orientation and tiered huddles, as part of their high-reliability organizational journey.[25] The Director further stated leaders strive to foster an environment where employees feel safe reporting adverse events; they also discuss *Good Catch* experiences daily and share the information in the Director's weekly message sent to all employees. Additionally, the leaders recognize employees with certificates for speaking up and sharing safety concerns.[26] The Patient Safety Manager said the number of reported patient safety events had increased. According to the Chief of Staff, leaders encourage staff to enter events in the Joint Patient Safety Reporting system, and the Patient Safety Manager reviews and tracks each event.[27] The Chief of Staff also described working with quality management staff to analyze each case, coordinate clinical reviews, and discuss the type of disclosure warranted.

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022. The Chief, Quality Management confirmed none of these types of events occurred during the time frame.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[25] Tiered huddles are brief communication meetings including employees ranging from frontline staff to senior leaders. The goal is to proactively identify and address any systemic concerns such as safety, staffing, resource allocation, and operational issues. "A high-reliability organization (HRO) is an organization with a goal of achieving 'zero harm' in an environment where accidents are expected due to complexity or risk factors." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

[26] "The 'Good Catch Award' recognizes employees who report close calls or other patient safety concerns." "VA Boston Displays Transparency in Patient Safety," VHA National Center for Patient Safety, accessed January 22, 2024, https://www.patientsafety.va.gov/VA_Boston_Displays_Transparency_in_Patient_Safety.asp.

[27] The Joint Patient Safety Reporting system is used to standardize "event capture and data management on medical errors and close calls/near misses." "VHA National Center for Patient Safety Frequently Asked Questions," Department of Veterans Affairs, accessed January 22, 2024, https://www.patientsafety.va.gov/about/faqs.asp.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[28] 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.[29] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[30]

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.[31] 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.[32]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[33] 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."[34] 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.[35]

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

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[30] VHA Directive 1100.16.

[31] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[33] 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.

[34] VHA Directive 1190.

[35] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[36] 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."[37]

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.[38] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[39]

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 an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[40]

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.[41] 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 each facility to have credentialing and

[36] 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.)

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[42]

The OIG interviewed key managers and selected and reviewed the privileging folders of 24 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[42] 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.

Environment of Care

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

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

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

- Montgomery campus
  - Emergency Department
  - Intensive care unit
  - Medical/surgical inpatient unit
  - Same day surgery clinic
  - Specialty clinic
- Tuskegee campus
  - Community living centers (GB and 1B)
  - Mental health inpatient unit

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

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

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

- Primary care clinic

Environment of Care Findings and Recommendations

The OIG made no recommendations.

Mental Health: Suicide Prevention Initiatives

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

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[50] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[51]

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

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 49 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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

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

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

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

[50] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[51] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

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

Mental Health Findings and Recommendations

VHA requires providers to complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen.[53] The OIG estimated that providers did not complete the evaluation following a positive screen for 35 (95% CI: 22 to 48) percent of patients, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[54] When providers do not complete the evaluation, they may miss opportunities to identify patients who are at imminent risk for suicide and intervene. The Associate Chief of Staff, Ambulatory Care and the Acting Associate Chief of Staff, Mental Health identified staff vacancies and the lack of comprehensive local screening and evaluation policies as factors contributing to providers inconsistently evaluating patients following the positive screen.

Recommendation 1

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

Healthcare system concurred.

Target date for completion: August 31, 2024

Healthcare system response: The Chief of Staff will ensure providers complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen and will monitor until 90 percent compliance is maintained for six consecutive months. The denominator is the total number of positive suicide risk screens each month. The numerator is the number of Comprehensive Suicide Risk Evaluations completed within 24 hours of a positive suicide risk screen for a Veteran. The Suicide Prevention staff has begun data collection and will monitor until 90 percent compliance is maintained for six consecutive months. Currently the data is reviewed twice daily for Veterans who have a positive suicide risk screen. For any positive suicide risk screens identified without a Comprehensive Suicide Risk Evaluation completed, email communication is sent to the provider requesting completion of the Comprehensive Suicide Risk Evaluation. Suicide Prevention Program Support Assistant will complete daily audits and report to the Suicide Prevention Coordinator. The Suicide Prevention Coordinator will report quarterly compliance in the Quality and Patient Safety Council.

[53] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

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

VHA requires suicide prevention coordinators to report suicide-related events monthly to "local mental health leadership and quality management."[55] Mental health leaders informed the OIG that the Suicide Prevention Coordinator did not report suicide-related events to required staff and leaders during FY 2022. The Suicide Prevention Coordinator's lack of monthly reporting may hinder leaders' oversight and result in missed opportunities for them to improve suicide prevention initiatives. The Suicide Prevention Coordinator and the Program Manager, Workplace Violence Prevention Program reported believing the monthly suicide prevention presentations shared with some staff, which did not include mental health leaders or quality management staff, met the requirements.

Recommendation 2

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

Healthcare system concurred.

Target date for completion: February 29, 2024

Healthcare system response: The Chief of Staff will ensure the Suicide Prevention Coordinator reports suicide-related events monthly to mental health leaders and quality management staff. The Veterans Integrated Service Network Chief Mental Health Officer developed and standardized a tracking tool which was adopted by all facilities within the network. The facility Suicide Prevention Coordinator implemented the tracking tool and monitoring began in February 2023. The Suicide Prevention Coordinator officially began reporting suicide-related events monthly to mental health leaders and quality management staff in May 2023. The Suicide Prevention Coordinator reported monthly in the Quality and Patient Safety Council beginning May 2023 and transitioned to quarterly reporting beginning February 2024. The standardized tracking tool is also sent via email communication monthly to mental health leadership and quality management staff. The denominator equals the total number of suicide-related events that occurred each month. The numerator equals the total number of suicide-related events reported to mental health leadership and quality management staff each month.

[55] VHA Directive 1160.07.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• None
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen. • The Suicide Prevention Coordinator reports suicide-related events monthly to mental health leaders and quality management staff.

Appendix B: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated healthcare system reporting to VISN 7.[1]

Table B.1. Profile for Central Alabama Veterans Health Care System (619) (October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$426,127,573	$453,589,449	$524,568,057
Number of:			
• Unique patients	49,012	51,237	52,968
• Outpatient visits	433,369	488,472	484,796
• Unique employees§	1,441	1,571	1,492
Type and number of operating beds:			
• Community living center	160	160	160
• Domiciliary	73	73	73
• Medicine	27	27	27
• Mental health	30	30	30
• Rehabilitation medicine	10	10	10
• Residential psychiatry	12	12	12
• Surgery	4	4	4
Average daily census:			
• Community living center	41	27	33
• Domiciliary	46	28	48
• Medicine	10	14	12
• Mental health	15	16	21
• Rehabilitation medicine	0	0	0
• Residential psychiatry	4	4	5

[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 healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census, cont.:			
• Surgery	0	0	0

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

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

**October 1, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 22, 2024

From: Director, VA Southeast Network (10N7)

Subj: Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System in Montgomery

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

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

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

(Original signed by:)

Benita Miller for
David M. Walker, MD, MBA

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: February 14, 2024

From: Director, Central Alabama Veterans Health Care System (619)

Subj: Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System, (CAVHCS) Montgomery Campus

To: Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review and comment on the Office of Inspector General, Comprehensive Healthcare Inspection of the CAVHCS, Montgomery Campus. I concur with the recommendations in the report.
2. CAVHCS remains committed to ensuring our Veterans receive health care of the highest quality.

(Original signed by:)

Valerie Russell, FAC-P/PM, MSM
Acting Director

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