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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama

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Figure 1. *Tuscaloosa VA Medical Center in Alabama.*
Source: https://www.va.gov/tuscaloosa-health-care/locations/tuscaloosa-va-medical-center/ (*accessed July 14, 2023*).

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
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 Tuscaloosa VA Medical Center in Alabama. 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 Tuscaloosa VA Medical Center during the week of May 22, 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 two recommendations to the Director and Chief of Staff in the Medical Staff Privileging and Environment of Care areas of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 18.

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 20–21, 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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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 Tuscaloosa 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 Tuscaloosa VA Medical Center includes outpatient clinics in Alabama. General information about the medical center can be found in appendix B.

The OIG inspected the Tuscaloosa VA Medical Center during the week of May 22, 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 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 Tuscaloosa VA Medical Center occurred in February 2020. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews 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 Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. 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 approximately one year. The Director was on leave during part of the OIG inspection, and the Chief of Staff was serving temporarily as the acting Director, while the Assistant Chief of Staff, Medicine was serving as the acting Chief of Staff.

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

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

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

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

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $260,945,700 had increased by approximately 18 percent compared to the previous year's budget of $221,145,414.[10] The acting Director said leaders used some of the funds to increase salaries for registered nurses, licensed practical nurses, and nursing assistants by 10 percent and offer other retention incentives. The ADPCS indicated that the budget was adequate for the services the medical center provided, and when unexpected costs arose, the VISN provided support. When asked how senior leaders would use additional funds, if available, the acting Director proposed increasing physician salaries and hiring more physicians. The ADPCS suggested creating a Veterans Health Administration (VHA) school for licensed practical nurses because many schools had closed nationwide. The ADPCS also proposed constructing a specialty care pavilion to provide patient care spaces for any new physicians that could be hired.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] 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.[12] Table 1 provides relevant survey results for VHA and the medical center over time.

The medical center's survey scores improved slightly over time. The ADPCS discussed focusing on psychological safety over the past three years and obtaining feedback from employees on related concerns. The ADPCS also highlighted the medical center's anonymous reporting phone line that employees can use to disclose any safety concerns.

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

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

[12] 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
Tuscaloosa VA Medical Center	3.6	3.7	3.8

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.[13] The OIG reviewed responses to two relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022.[14] Table 2 provides survey results for VHA and the medical center over time.

Survey scores indicate that patients' satisfaction with their primary care experiences significantly decreased in FY 2022, but satisfaction with specialty care increased. The ADPCS identified previous nursing shortages as a potential negative impact on scores. However, the ADPCS stated registered and licensed practical nurse primary care positions were fully staffed at the time of the site visit. The acting Chief of Staff indicated retirements from the primary care team, including five providers in July 2022, limited patients' access to care. The acting Chief of Staff added that the medical center worked with a clinical resource hub, a telehealth medicine resource provided by the VISN, to address staffing shortages.

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

[14] The medical center only provides inpatient services for mental health care and therefore does not have inpatient survey scores.

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
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	81.9	81.9	82.9	81.7	76.3
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	84.2	83.3	82.3	83.1	84.9

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

**The response average is the percent of "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 when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[17]

[15] 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/.

[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.

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

"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 OIG requested a list of adverse patient safety events that occurred during FY 2022. Quality management staff provided details for six sentinel events and three institutional disclosures and reported there were no large-scale disclosures completed during this time frame.

Three of the six sentinel events resulted in patient deaths. Of the three events that resulted in deaths, two did not have a completed institutional disclosure. For one of the two sentinel events without an institutional disclosure, the Risk Manager stated the patient's family did not respond to multiple attempts to schedule an institutional disclosure appointment. For the remaining sentinel event without an institutional disclosure, the Chief of Quality Management explained the Chaplain, the Director, and the medical officer on duty completed a clinical disclosure, and quality management staff completed a root cause analysis and reported the event to The Joint Commission.[22] However, the Chief of Quality Management said leaders believed an institutional disclosure was not warranted after the patient's autopsy results showed the manner of death was not related to a sentinel event.

[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(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

[22] "Clinical disclosure of adverse events is a process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient's care." VHA Directive 1004.08. A root cause analysis "is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1).

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[23] 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.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[25]

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.[26] 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.[27]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[28] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[29] Peer reviews are "intended to promote confidential and non-punitive 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 team requested a list of patient deaths that occurred within 24 hours of inpatient admission and patient suicides that occurred within seven days of discharge from an inpatient mental health unit during FY 2022, and medical center staff reported no patients met these criteria.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[25] VHA Directive 1100.16.

[26] VHA Handbook 1050.01; VHA Directive 1050.01(1).

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

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

[29] VHA Directive 1190.

[30] VHA Directive 1190.

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."[31] 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."[32]

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.[33] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[34]

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 (OPPE) to ensure the continuous delivery of quality care.[35]

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.[36] 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

[31] 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.)

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[37]

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

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to recommend continued privileges based, in part, on OPPE activities such as direct observation, chart reviews, and clinical discussions. VHA also requires an executive committee of the medical staff (known as the Medical Executive Committee at this medical center) to recommend continued privileges based on OPPE results.[38] The OIG found that service chiefs did not consistently recommend LIPs' reprivileging to the Medical Executive Committee based on OPPE activities. Consequently, the Medical Executive Committee did not consider all OPPE results in their reprivileging recommendations. This may have resulted in the LIPs continuing to deliver care without thorough practice evaluations. The Executive Assistant, Chief of Staff acknowledged a lack of attention to detail that resulted in service chiefs recommending privileges to the committee without basing them on OPPE activities.

Recommendation 1

1. The Chief of Staff ensures service chiefs recommend continuation of current privileges based on Ongoing Professional Practice Evaluation activities.

[37] 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.

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

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: Practitioner Profiles containing Ongoing Professional Practice Evaluation (OPPE) reviews are to be made available at Medical Executive Committee (MEC) meetings for the practitioner being re-privileged for review and discussion, and minutes will reflect OPPE data reviewed with service chief's and committee's recommendation to continue current privileges.

Clinical service chiefs review up to four previous OPPE cycles when recommending renewal of privileges. Clinical service chiefs sign the OPPE forms and attest in an electronic credentialing and privileging software that OPPE results have been reviewed and no concerns are noted. The Medical Executive Committee Credentials Subcommittee of the MEC also reviews the OPPEs when reviewing clinical service chiefs' recommendations for renewing practitioners' privileges. Credentialing and Privileging Office staff will assist in obtaining OPPE reviews for use during the MEC meeting and make the OPPE data available for the Director's review with the minutes included. The Credentialing and Privileging Manager will monitor compliance with service chiefs' OPPE review and report quarterly to the Clinical Executive Board until 90 percent compliance is achieved and sustained for six consecutive months.

Quality Management staff will monitor and conduct monthly audits of MEC meeting minutes to ensure all action items have appropriate follow-up until a 90 percent compliance rate is sustained for six consecutive months.

The numerator will be the number of practitioners' OPPEs with evidence that the service chief's and MEC's recommendation to continue current privileges was based in part on the results of OPPE activities. The denominator will be the number of practitioners' OPPEs that service chiefs and MEC reviewed.

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."[39] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[40]

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.[41]

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

- Community living center (Eagles' Cove)
- Mental health unit (Acute 1)
- Primary care clinic (Teams 10 and 13)

Environment of Care Findings and Recommendations

VHA requires all medical facilities to provide a "safe, clean and high-quality environment."[42] The OIG found damaged walls in two patient care areas inspected.[43] Additionally, the OIG observed dirty refrigerators in two food storage areas.[44] Damaged and dirty patient care areas increase the risk of contamination and pathogen exposure. The Chief, Engineering reported

[39] 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.)

[40] 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.

[41] 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.)

[42] VHA Directive 1608.

[43] The OIG found deficiencies in the primary care clinic-Team 13 and community living center.

[44] The OIG found deficiencies in the mental health unit and community living center.

engineering staff were unaware of the damaged walls because nursing staff did not submit work orders and there was insufficient coordination between the two services. Additionally, the nurse managers and Chief, Environmental Management Service stated staff did not clean the refrigerators due to a lack of clarity regarding cleaning responsibility.

Recommendation 2

2. The Director ensures staff keep patient care areas safe and clean.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: A Standard of Operating Procedure (SOP) will be developed to address the process for cleaning refrigerators in patient care areas. Nurse managers in the following areas will educate staff on the new SOP: Environmental Management Services, Nutrition and Food Service, Geriatrics and Extended Care Services, and inpatient Mental Health. The target completion for SOP development and staff education is May 31, 2024. Compliance will be monitored through staff signatures indicating completion of education. Quality Management staff will obtain sign-in sheets from respective service chiefs as evidence of staff attendance until a compliance rate of 90 percent is obtained. All refrigerators located in inpatient care areas will be cleaned weekly. Weekly cleaning logs will be submitted by the respective nurse managers to the Associate Chief Nurses for Mental Health and Geriatrics and Extended Care with the goal of 90 percent compliance for six consecutive months.

During the OIG CHIP Survey in May 2023, work orders were placed and damaged walls were repaired within 30 days of survey completion. All staff are required to complete an annual Talent Management System (TMS) module with step-by-step instructions on entering work orders into the VA based software application used to report and track work orders until completion. The Associate Chief Nurses for Mental Health and Geriatrics and Extended Care will track and monitor completion of TMS education and will provide data to Quality Management staff until a 90 percent compliance is achieved.

Mental Health: Suicide Prevention Initiatives

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

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.[49] 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.[50]

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.[51]

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 18 patients who had a positive suicide screen in FY 2022 and received primary care services.

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

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

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

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

[49] 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.)

[50] 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.)

[51] 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

The OIG made no recommendations.

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 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 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 two OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the 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	• None
Medical Staff Privileging	• Service chiefs recommend continuation of current privileges based on Ongoing Professional Practice Evaluation activities.
Environment of Care	• Staff keep patient care areas safe and clean.
Mental Health: Suicide Prevention Initiatives	• None

Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) affiliated medical center reporting to VISN 7.[1]

Table B.1. Profile for Tuscaloosa VA Medical Center (679)
(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	$195,340,328	$221,145,414	$260,945,700
Number of:			
• Unique patients	15,451	15,621	15,376
• Outpatient visits	179,039	190,243	189,782
• Unique employees§	968	978	973
Type and number of operating beds:			
• Community living center	134	134	134
• Domiciliary	128	128	128
• Psychiatry	43	43	43
• Compensated work therapy–transitional residence	12	12	12
Average daily census:			
• Community living center	117	100	102
• Domiciliary	83	51	78
• Psychiatry	37	33	30
• Compensated work therapy–transitional residence	6	2	10

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 "3" indicates a facility with "low volume, low risk patients, few or no 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: February 23, 2024

From: Director, VA Southeast Network (10N7)

Subj: Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama

To: Director, Office of Healthcare Inspections (54CH01)

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

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

(Original signed by:)

Benita Miller for
David M. Walker, MD, MBA, FACHE

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 9, 2024

From: Director, Tuscaloosa VA Medical Center (679)

Subj: Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama

To: Director, VA Southeast Network (10N7)

I have completed a full review of our facility's Office of Inspector General Comprehensive Healthcare Inspection Draft Report and concur with the draft report, recommendations, and action plans.

(Original signed by:)

John F. Merkle, FACHE, VHA-CM
Director, Tuscaloosa VAMC

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