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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation that a physician (subject physician) who was not privileged provided care to intensive care unit (ICU) patients at the Overton Brooks VA Medical Center (facility) in Shreveport, Louisiana.[1] Additionally, the OIG identified concerns related to a quality review completed after facility leaders became aware of the event.

Inspection Results

The OIG substantiated that the subject physician, a fellow in training at an academic affiliate, provided patient care with attending physician oversight for three hours in the facility's ICU.[2] The OIG reviewed the electronic health records of all facility ICU patients hospitalized at the time the subject physician provided care and did not identify any adverse events or clinical harm. The OIG determined that failure to follow the Veterans Health Administration (VHA) health professions trainee (trainee) onboarding process and lack of oversight of physician coverage for the ICU contributed to this event. The Facility Director chartered a root cause analysis (RCA) after becoming aware of the event. However, deficiencies with the RCA team's use of the RCA process resulted in not exploring how the subject physician was onboarded as a trainee or provided care in the facility's ICU, and patient safety vulnerabilities were left unresolved. The OIG found the RCA team did not follow VHA-required guidelines and identified concerns with the reliability of the RCA team's assessment and conclusion.

Trainee Onboarding Process Failures

VHA uses a specific trainee verification process, which includes credentialing, to ensure training program participation requirements are met. The subject physician, a pulmonary disease and critical care medicine fellow at the academic affiliate, was improperly onboarded when the resident student coordinator (coordinator) facilitated the VHA onboarding process without a Trainee Qualifications and Credentials Verification Letter (verification letter). A verification letter would have confirmed the subject physician's enrollment in a fellowship if there was an active corresponding rotation at the facility.

In the spring of 2022, an academic affiliate employee sent a list of all affiliate trainees who—regardless of level or area of practice—may rotate through the facility, to the facility's

[1] The credentialing and privileging process must be completed before a practitioner's provision of patient care. VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

[2] A fellow is a physician "in a program of accredited graduate education who has completed the requirements for eligibility for first board certification" and who participates in patient care under the direction of a supervising practitioner (attending). VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019.

coordinator. The coordinator then sent an email to all the trainees listed. The email included onboarding steps and guidance to disregard the email if the trainee was not rotating through the facility. Although the facility's pulmonary disease and critical care medicine fellowship program ended in 2020, the subject physician received the email, completed the onboarding steps, and was issued a Personal Identity Verification card and VA computer access. When asked, the subject physician told the OIG of completing the onboarding process because of the desire to work as a paid employee at the facility but was unaware that certain credentials were needed.

The coordinator explained initiating trainee onboarding without a verification letter was not unusual as it was done to prevent a delay in rotation start dates.[3] In early 2024, VA instituted a new process that established safeguards to ensure the completion of verification letters prior to trainee onboarding.

Oversight of Intensive Care Unit Physician Coverage Failures

Service chiefs are responsible for ensuring no provider within the service they are overseeing is onboarded, scheduled, or provides patient care before the completion of the credentialing process.[4] The OIG learned an intermittent physician managed a coverage pool list used to identify physicians who assisted ICU attendings with patient care and documentation when residents were not available. The list consisted of pulmonary disease and critical care medicine fellows from the academic affiliate who were hired and independently credentialed and privileged at the facility as fee-basis hospitalists, separate from the academic affiliate fellowship program. In summer 2023, the subject physician was added to the list after informing the intermittent physician of being credentialed and wanting to work at the facility. The subject physician believed that credentials were in place through the academic affiliate and VHA onboarding process and did not understand a separate process was needed to work as a fee-basis hospitalist.

The subject physician arrived at the facility in late 2023 to provide patient care in the ICU but reported only working three hours due to being unable to sign notes in electronic health records. Six days later, the chief of medicine learned the subject physician lacked the credentials and privileges to work as a provider at the facility. Although responsible for the oversight of physician scheduling in the ICU, the chief of medicine could not provide details about the coverage pool scheduling. The chief of medicine reflected, "obviously the oversight failed."

The OIG determined deficient oversight allowed the subject physician to be scheduled and provide patient care without credentials and privileges. The OIG concluded the chief of medicine

[3] This practice was started due to a history of inconsistent receipt of timely verification letters from the academic affiliate and was in use when the coordinator started in 2012.

[4] VHA Directive 1100.20(1), *Credentialing of Health Care Providers*, September 15, 2021, amended May 9, 2024, and again to 1100.20(2) on September 11, 2024. The guides contain the same or similar language regarding completing the service chief responsibilities unless otherwise noted.

did not ensure a process was implemented to verify physicians in the coverage pool were credentialed and privileged. This contributed to the subject physician being placed onto the coverage pool list.

Deficiencies with a Root Cause Analysis

Facility staff completed an RCA to determine how the subject physician was able to provide care in the ICU. The OIG identified RCA deficiencies related to team composition, process steps, and timeliness. Moreover, the root cause statement contained inaccurate information, did not identify underlying system vulnerabilities, or ultimately determine the root cause of the event. If the RCA team had properly executed the process steps, a more thorough examination of the event may have occurred. The OIG is concerned that when staff fail to identify the root cause of a patient safety event, the underlying system vulnerabilities that put patients at risk are not identified.

The RCA team did not include a leader who ensured alignment with required RCA components such as assigning a team member as a recorder or using initial triage questions during analysis of the event. Additionally, the team did not include a subject matter expert (SME) who was well versed in the RCA focus area. Without an SME, knowledge gaps remained. Further, the RCA was not completed within the required 45-day time frame.[5] The quality, safety, and value chief thought an SME was on the team and explained the RCA was intentionally delayed because of an increase in patient safety staff workload.

The Chief of Staff commented that the team did not meet RCA criteria because it lacked an understanding of the event, and the team did not consist of individuals with knowledge of the topic. Based on interviews, the OIG surmised that the Facility Director's decision to concur with the RCA findings and action plan was based on a review of presentation slides. However, the OIG found the slides did not include sufficient information to understand how the subject physician provided care in the ICU or how the identified root cause and subsequent action plan would prevent a similar event. The Facility Director could not recall specific details on what contributed to the decision to concur.

The OIG also identified a concern regarding a facility practice involving an additional concurrence step in the RCA process, not outlined in VHA guidance.[6] Before the final RCA presentation to the Facility Director, the RCA team meets with facility leaders responsible for implementing the action plan to share information and obtain feedback and agreement with the recommendation. The OIG is concerned about the vulnerabilities that exist related to the information that can be shared during this step as an RCA is a protected quality management

[5] The OIG examined facility RCA data from October 1, 2023, through September 30, 2024, and identified a trend in timeliness issues. Eight of nine RCAs exceeded the 45-day requirement.

[6] VHA National Center for Patient Safety (NCPS), *Guide to Performing Root Cause Analysis*, version 13, February 2024, updated to version 14, March 2024. The guidebooks contain the same or similar language regarding conducting RCAs unless otherwise noted.

activity.[7] An additional vulnerability of this step is the potential for service line leaders to influence the trajectory of the RCA findings.

The OIG made a recommendation to the Under Secretary for Health to evaluate VHA's use of an additional RCA concurrence step.[8] The OIG made three recommendations to the Facility Director related to trainee onboarding requirements, oversight of intensive care unit physician credentialing and privileging, and completion of root cause analyses according to VHA policy.

VA Comments and OIG Response

The Acting Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes A, B, and C). The OIG will follow up on the planned actions until they are completed.

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Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

[7] Confidentiality of medical quality assurance records, 38 U.S.C. § 5705; VHA Directive 1320, *Quality Management and Patient Safety Activities That Can Generate Confidential Records and Documents*, July 10, 2020. Identifying information includes names or position titles and locations; NCPS, *NCPS Guidance for De-identifying RCAs*, June 20, 2024; NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[8] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

Contents

Abbreviations

ICU	intensive care unit
OIG	Office of Inspector General
PIV	personal identity verification
PSO	patient safety officer
QSV	quality, safety, and value
RCA	root cause analysis
SME	subject matter expert
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation that a physician (subject physician) who was not privileged provided care to intensive care unit (ICU) patients at the Overton Brooks VA Medical Center (facility) in Shreveport, Louisiana.[1] Additionally, the OIG identified concerns related to a root cause analysis (RCA) completed after facility leaders became aware of the event.

Background

The facility is part of Veterans Integrated Service Network (VISN) 16, the South Central VA Health Care Network, and consists of one inpatient hospital and four outpatient clinics.[2] The facility provides comprehensive health care; including medicine, surgery, and primary care; to patients in Louisiana, southern Arkansas, and eastern Texas. The Veterans Health Administration (VHA) classifies the facility as a level 1c.[3] The hospital has 107 accredited inpatient beds; the chief of medicine reported 10 are designated ICU beds.

Allegations and Related Concerns

In late 2023, the OIG received an allegation that a nurse practitioner improperly scheduled shift coverage and "allowed an unprivileged, non-VA employee to provide care to ICU Veterans" at the facility. The OIG contacted VISN leaders in March 2024 regarding the allegation. The VISN response, received June 27, 2024, substantiated the allegation, and indicated an issue brief and an RCA were completed.[4] The OIG determined the response did not indicate that identified vulnerabilities were resolved and opened a hotline on July 11, 2024. The OIG reviewed the electronic health records of all facility ICU patients hospitalized on the day in question, and did not identify any adverse events or clinical harm. Facility leaders also completed a clinical review and did not identify any patient harm.

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[1] The credentialing and privileging process must be completed before a practitioner's provision of patient care. Credentialing is a verification process of screening and evaluating a provider's required qualifications including licensure, education, relevant training, and experience. Privileging refers to the process of approving a licensed independent practitioner to administer specific patient care and occurs after the practitioner's credentials are verified. VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

[2] The clinics are in: Longview, Texas; Shreveport and Monroe, Louisiana; and Texarkana, Arkansas.

[3] VHA Office of Productivity, Efficiency, and Staffing (OPES), "Data Definitions: VHA Facility Complexity Model," October 1, 2023. VHA facilities are classified at levels 1a, 1b, 1c, 2, or 3. Level "1a facilities are the most complex and the level 3 facilities are the least complex."

[4] An RCA is a quality review used "to study health care-related adverse events and close calls" with a goal of "find[ing] out what happened, why it happened, and how to prevent it from happening again." "Root Cause Analysis," VHA National Center for Patient Safety, accessed October 2, 2024, https://www.patientsafety.va.gov/professionals/onthejob/rca.asp.

Scope and Methodology

The OIG conducted a virtual site visit and completed interviews from August 8 through October 15, 2024. The OIG interviewed the subject physician; the previous and current VISN patient safety officers (PSO); and selected current and former facility leaders, providers, and staff.[5] The OIG reviewed relevant VHA and facility policies and procedures, organizational charts, email communications, and quality reviews. The OIG did not independently verify VHA data for accuracy or completeness.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

[5] Of note, the OIG interviewed both the Chief of Staff and former Chief of Staff. The Chief of Staff began as the acting Chief of Staff in February 2024 and transitioned into the chief of staff role in May 2024. The former Chief of Staff held the position from October 2022 to February 2024 and transitioned to an emergency department physician at the facility.

Inspection Results

1. Deficiencies in Trainee Onboarding and ICU Oversight Processes

The OIG substantiated that in late 2023, the subject physician provided patient care for three hours in the facility's ICU with attending physician oversight. The OIG determined that failure to follow the VHA health professions trainee (trainee) onboarding process and lack of oversight of physician coverage for the ICU contributed to this event.[6]

Trainee Onboarding Process

VHA uses a specific trainee verification process to ensure the requirements to participate in the training program are met. To initiate each trainee's verification process, an academic affiliate must send a Trainee Qualifications and Credentials Verification Letter (verification letter) to a medical center's designated education officer. The verification letter confirms the academic affiliate verified that the trainee has the required credentials to participate in the training program, is eligible for appointment to a position, and documents VA eligibility requirements so no further VA credentialing and privileging is needed. Once the verification letter is received, the designated education officer is responsible for ensuring trainees complete the required VHA onboarding process steps and for submitting the verification letter to the medical center director for signature.[7] A trainee must not be issued a Personal Identity Verification (PIV) card, which allows for VA computer access, or participate in patient care until the medical center director concurs the trainee requirements are met by signing the verification letter.[8]

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[6] Health professions trainees are individuals who are "appointed to temporary positions in one or more VHA medical facility[ies] performing clinical … training experiences under supervision to satisfy program or degree requirements." VHA Office of Academic Affiliations, *Guide to Completing the Trainee Qualifications and Credentials Verification Letter (TQCVL) For Affiliate and VA Program Directors*, version 5, February 2023; VHA Office of Academic Affiliations*, Onboarding Veterans Health Administration (VHA) Health Professions Trainees (HPTs), Guidance for Education Staff*, 2020. The VA onboarding process for new trainees at a VA medical center requires completing documentation forms related to fingerprinting and background check; computer user account request and training; and issuance of a Personal Identity Verification credential card.

[7] VHA Office of Academic Affiliations, *Guide to Completing the Trainee Qualifications and Credentials Verification Letter (TQCVL) For Affiliate and VA Program Directors*, version 3, February 2021, updated to version 4, June 2021, and again to version 5, February 2023. The guides contain the same or similar language regarding completing the TQCVL unless otherwise noted.

[8] VA Handbook 0735, *Homeland Security Presidential Directive 12 (HSPD-12) Program*, March 24, 2014. PIV cards are issued during the onboarding process and are "used to verify identities in order to enter federal buildings or gain access to federal computer networks." The OIG learned the subject physician physically obtained the PIV card in early 2023. The medical center director can also designate the medical center chief of staff or the education officer to sign the verification letter. VHA Office of Academic Affiliations, VHA Office of Academic Affiliations, *Guide to Completing the Trainee Qualifications and Credentials Verification Letter (TQCVL) For Affiliate and VA Program Directors*, version 5, February 2023; VHA Office of Academic Affiliations, *Onboarding Veterans Health Administration (VHA) Health Professions Trainees (HPTs), Guidance for Education Staff*, 2020.

The OIG learned during an interview that an academic affiliate employee sends a list of affiliate trainees who—regardless of level or area of practice—may rotate through the facility, to the facility's resident student coordinator (coordinator).[9] Through review of electronic communication, the OIG learned that although the facility's pulmonary disease and critical care medicine fellowship program ended in 2020, an academic affiliate employee continued to include pulmonary disease and critical care medicine fellows on the list.[10] A fellow is a physician "in a program of accredited graduate education who has completed the requirements for eligibility for first board certification" and who participates in patient care under the direction of a supervising practitioner (attending).[11] During an interview and through review of electronic communication, the OIG learned that in early spring 2022, an academic affiliate employee included the subject physician's name as a pulmonary disease and critical care medicine fellow on the list of trainees who were scheduled to start at the facility that July. The coordinator then sent an email to all the trainees on the list. The email included VA trainee onboarding instructions and guidance stating, "If you won't rotate at the VA at all, please disregard this email."

Nonetheless, the subject physician completed VA trainee onboarding steps listed in the email. Steps included the application for trainees, appointment affidavit, declaration for federal employment, fingerprint form, computer new user request form, and required education modules. The coordinator told the OIG of then finalizing the paperwork needed for a background check. Following the completed background check, the coordinator emailed a medicine service line employee in late spring 2022 to initiate issuance of a PIV card and the processing of VA computer access for the subject physician.

When asked, the subject physician told the OIG of completing the onboarding process "because I was trying to moonlight [at the facility], but I didn't know I needed certain credentials."[12] The subject physician further stated,

> So, I think I was just confused most of the time. If obviously, if someone at some point said, hey, you don't have the right credentials, you can't be here, I would have been like, ok, let me figure this whole thing out before I actually start. But I think I was just … kind of misinformed.

[9] The coordinator is a facility employee who reports to the chief of education and is responsible for processing trainee onboarding.

[10] The OIG learned through email from the academic affiliate that the facility's pulmonary disease and critical care medicine fellowship ended in the spring of 2020 as several attending physicians left the facility, affecting the consistent staffing needed to provide trainee oversight. Of note, other trainee rotations occur at the facility.

[11] VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019.

[12] VHA Directive 1400.16, *VA Employees with Secondary Appointments As Health Professions Trainees*, May 31, 2023. According to the directive, moonlighting refers to trainees who have a "secondary VA appointment as a staff provider."

The OIG determined the coordinator improperly facilitated the onboarding of the subject physician as a trainee when the VHA onboarding process progressed without a verification letter. The coordinator acknowledged taking the list of names received from the academic affiliate employee and emailing VA trainee onboarding instructions to the pulmonary disease and critical care medicine fellows, despite knowing that the fellowship rotation had ended at the facility. When asked about ongoing communication with the subject physician about onboarding, the coordinator stated, "it didn't dawn on me" that the subject physician was not rotating through the facility.

The OIG also questioned the coordinator about facilitation of the subject physician's VA onboarding without a verification letter from the academic affiliate. The coordinator explained initiating trainee onboarding without a verification letter was not unusual as it was done to prevent a delay in rotation start dates. The coordinator also said that this practice was started due to a history of inconsistent receipt of timely verification letters from the academic affiliate.[13] When asked whether facility leaders were aware of delays in receiving verification letters from the academic affiliate, the coordinator reported managing [the delays] "on my own" and not informing facility leaders. The Facility Director told the OIG that trainees are expected to have a verification letter prior to coming to the facility.

In early 2024, the VA Office of Information and Technology initiated a new electronic process to standardize how VA employees and trainees are granted a PIV card allowing access to VA computer systems. Trainee onboarding using the new electronic process cannot be initiated without information from a completed verification letter.[14] At a medical center, once the verification letter is received, the coordinator must enter information from the verification letter into the electronic system; this prompts a system-generated email to the trainee.[15] The email contains instructions for the trainee to complete the computer access process. In an interview, the coordinator confirmed the new electronic process has been in use since early 2024.

The OIG found deficiencies with the facility's trainee onboarding process contributed to the subject physician's onboarding as a trainee without a verification letter. A verification letter would have allowed the coordinator to confirm whether the subject physician was enrolled in a fellowship that had an active corresponding rotation at the facility. The OIG recognizes that the

[13] The OIG learned the process was in use when the coordinator started in 2012.

[14] Principal Deputy Assistant Secretary, Office of Information and Technology, "Establishing the Account Provisioning/Deprovisioning System as VA's Enterprise Tool to Provision/Deprovision Accounts for All User Types (Contractors, Volunteers, Employees, Health Profession Trainees Without Compensation and Accredited Representatives," memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, January 11, 2024; VA Office of Information and Technology, Account Provisioning/Deprovisioning System, "HPT WOC Provisioning – HPT Provisioning for Coordinators and Research Recruiters," April 2024, V2.2.

[15] VA Office of Information and Technology, Account Provisioning/Deprovisioning System, "HPT WOC Provisioning – HPT Provisioning for Coordinators and Research Recruiters."

new electronic process now exists, which establishes safeguards to ensure the completion of verification letters prior to trainee onboarding.

Oversight of Intensive Care Unit Physician Coverage Process

VA policy states that through "the credentialing process, [licensed independent practitioners] must meet the clinical qualifications required to provide quality care to patients and be granted privileges."[16] Credentialing occurs before privileging and assesses clinical training and competency to verify licensed independent practitioners can perform the requested privileges.[17] A licensed independent practitioner is granted authorization through the privileging process to practice based on the individual's clinical competence. Privileging does not apply to trainees, except those who function independently outside the scope of their training program.[18] Service chiefs are responsible for ensuring no provider within the service they are overseeing is onboarded, scheduled, or provides patient care before the completion of the credentialing process.[19]

The OIG learned an intermittent physician developed and managed a coverage pool list used to identify physicians who assisted ICU attendings with patient care and documentation when residents were not available.[20] The coverage pool list consisted of pulmonary disease and critical care medicine fellows from the academic affiliate who were also employed at the facility as fee-basis hospitalists.[21] These fee-basis hospitalists were hired and credentialed and privileged independent of and separate from the academic affiliate fellowship program.[22] In summer 2023, the subject physician informed the intermittent physician of being "credentialed for quite some time for the VA" and expressed a desire to work at the facility. The subject physician told the

[16] VHA Directive 1100.21(1).

[17] VHA Directive 1100.21(1).

[18] VHA Directive 1100.21(1). Trainees are credentialed through an academic affiliate's verification process. VHA Office of Academic Affiliations, *Guide to Completing the Trainee Qualifications and Credentials Verification Letter (TQCVL) For Affiliate and VA Program Directors*, version 5.

[19] VHA Directive 1100.20(1), *Credentialing of Health Care Providers*, September 15, 2021, amended May 9, 2024, and again to 1100.20(2) on September 11, 2024. The guides contain the same or similar language regarding completing the service chief responsibilities unless otherwise noted.

[20] VHA policy is to use "qualified individuals on a part-time or intermittent basis when necessary to alleviate recruitment difficulties and … when the employee's services are required on a less than a full-time basis." VA Handbook 5005/161*, Staffing*, January 29, 2024; "A resident is an individual who is engaged in an accredited graduate training program for physicians … and who participates in patient care under the direction of supervising practitioners [attending]." VHA Directive 1400.01.

[21] VA Handbook 5007/41, *Pay Administration*, September 30, 2011. A physician may be appointed on a fee basis to provide coverage when no other staffing options are available, and use is necessary to meet staffing levels; A hospitalist is a physician "who specializes in providing and managing the care and treatment for hospitalized patients." *Merriam-Webster.com Dictionary*, "hospitalist," accessed December 3, 2024, https://www.merriam-webster.com/dictionary/hospitalist.

[22] The OIG independently reviewed and confirmed the fee-basis hospitalists were credentialed and privileged to provide care at the facility.

OIG about believing credentials were in place through the academic affiliate and VHA onboarding process and did not understand a separate process was needed to work as a fee-basis hospitalist. The intermittent physician added the subject physician's name to the coverage pool list.

In the fall of 2023, an ICU nurse practitioner identified gaps in resident coverage for shifts the following month and contacted the intermittent physician. The intermittent physician texted the facility fee-basis hospitalists on the coverage pool list, inquiring about interest in covering shifts. The subject physician responded to the group "I can do the 24th" and then responded directly to the intermittent physician with "can likely cover the … 12th." The intermittent physician informed the ICU nurse practitioner that the subject physician would work the shift on the 24th and was checking on availability for the other shift. Communication continued between the subject physician and the intermittent physician regarding shift coverage availability but coverage for the 12th was not finalized.

The evening before the shift, the ICU nurse practitioner contacted the intermittent physician to confirm whether the subject physician was providing coverage the following day. When no response was received, the ICU nurse practitioner reported contacting the subject physician to inquire about availability. The subject physician confirmed availability for the following day and arrived at the facility to provide patient care in the ICU. However, the subject physician reported only working three hours due to the inability to sign electronic health record orders or notes. An attending physician was in the ICU during the time the subject physician was assisting with care. Six days later, the subject physician contacted the chief of medicine requesting compensation for the hours worked. This led to facility leaders' discovery that the subject physician was not an employee or a trainee at the facility.

Through review of email communication and speaking with an ICU leader, the OIG determined the chief of medicine provided oversight of the process for scheduling ICU attending physicians but was not involved in the coverage pool scheduling process, albeit aware of its existence.[23] When the OIG asked about the process of scheduling physicians from the coverage pool, the chief of medicine could not explain how this occurred or who was responsible. The chief of medicine also reflected, "obviously the oversight failed."

The intermittent physician reported the chief of medicine did not require formal approval to place physicians in the coverage pool and provided "leeway" in making the schedule. Further, the intermittent physician expressed an awareness that credentialing of physicians in the coverage pool was required but when asked how credentials and privileges are verified the intermittent physician stated,

[23] The chief of medicine was responsible for ICU scheduling oversight as the ICU director role had been vacant since April 2020. A fee-basis ICU physician coordinated the ICU attending physician schedule a month in advance and submitted the schedule to the chief of medicine for approval.

> I was wrong in thinking that [the subject physician] was entitled to work here. All of the other ones [fee-basis hospitalists] … had gotten credentialed at the VA … in order to [work at the facility] … while they were in fellowship [at the academic affiliate] … I don't think I'd have any particular paperwork … they would tell me that they had gone through credentialing.

The Chief of Staff was familiar with the process of using fee-basis hospitalists from the coverage pool list to support ICU attendings, particularly during periods when patient care would benefit from additional staff. However, the Chief of Staff explained the use of academic affiliate fellows as fee-basis hospitalists established conditions that allowed the subject physician to provide care in the ICU. The former Chief of Staff told the OIG that following the event, a discussion was held with the intermittent physician including verbal instructions that anyone providing support for the ICU attendings must be brought onboard according to VA policy.

In a late 2023 email, the OIG found the Chief of Staff contacted the former Chief of Staff stating the chief of medicine had stopped the coverage pool scheduling process. However, the OIG found that the process was occurring as recently as May 2024. Of note, the OIG learned that as of November 2024, the chief of medicine verified reviewing the credentials of the one remaining fee-basis hospitalist who can be scheduled to provide patient care in the ICU.

Although the subject physician only worked three hours and was unable to sign notes in the electronic health record, the OIG determined deficient oversight allowed the subject physician to be scheduled and provide patient care without credentials and privileges. The OIG concluded the chief of medicine did not ensure a process was implemented to verify physicians in the coverage pool were credentialed and privileged. This contributed to the subject physician being placed onto the coverage pool list.

2. Deficiencies with a Root Cause Analysis Process

Two days after the subject physician contacted the chief of medicine, the Chief of Staff alerted facility leaders that the subject physician provided care in the ICU. The following day, the Facility Director determined the need for an RCA to identify how this event occurred. The Facility Director emailed the chief of quality, safety, and value (QSV) to initiate the process.[24]

RCAs are used "to study health care-related adverse events and close calls" with a goal of "find[ing] out what happened, why it happened, and how to prevent it from happening again."[25] VHA outlines the specific process an RCA team should follow to increase understanding of an

[24] The QSV chief reported organizational alignment over the patient safety staff who are responsible for conducting RCAs.

[25] "Root Cause Analysis," VHA National Center for Patient Safety, accessed October 2, 2024, https://www.patientsafety.va.gov/professionals/onthejob/rca.asp.

event, identify knowledge gaps, and collect and analyze information.[26] The RCA may "not contradict itself or leave obvious questions unanswered."[27]

The OIG determined deficiencies with the RCA process left patient safety vulnerabilities unresolved and did not explore how a physician was allowed to provide care without privileges as the Facility Director initially requested. The OIG (1) found the RCA team did not follow VHA required guidelines, and (2) identified concerns with the reliability of the RCA team's assessment and conclusion.

VHA RCA Guidelines

VHA provides specific instructions regarding RCA team composition, process steps, and timeliness. The OIG found the RCA team did not: include individuals knowledgeable about the processes and systems under review; properly execute RCA steps; or complete the RCA within required time frames.

Team Composition

The patient safety manager is responsible for preparing the RCA charter, which must identify members and describe their specific roles on the team.[28] RCA team members should include a team leader and a subject matter expert (SME). A team leader is "well versed in the RCA process," and has the knowledge to ensure the team is "on track and aligned with the required components of the adverse event investigations."[29] In addition, a team leader's responsibilities include organizing meetings, ensuring deadlines are met, and assigning a team member the duty of a recorder at the first team meeting.[30] An SME "possess[es] intimate familiarity with the area, domain, clinical discipline, processes, and topic being investigated."[31]

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[26] The RCA protocol consists of steps that include chartering and training a team; developing an initial understanding of the event and knowledge gaps; conducting an investigation; analyzing information learned through tools such as final flow and cause-and-effect diagrams; determining the root cause and corrective actions; and presenting findings to the medical center director for concurrence. VHA National Center for Patient Safety (NCPS), *Guide to Performing Root Cause Analysis*, version 13, February 2024, updated to version 14, March 2024. The guidebooks contain the same or similar language regarding conducting RCAs unless otherwise noted.

[27] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[28] The patient safety manager is responsible for preparing the RCA charter for a medical center director's review and signature. VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. This directive was amended to VHA Directive 1050.01(1) on March 24, 2023, and amended again on March 5, 2024. The directives contain the same or similar language regarding conducting RCAs unless otherwise noted; NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[29] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[30] A recorder is responsible for documenting team meeting notes and interviews.

[31] NCPS, *Guide to Performing Root Cause Analysis*, version 14. Although additional roles on the team exist such as an advisor, and non-SME, for the purposes of this report, the OIG focused on the team roles responsible for providing expertise on the RCA focus area. The team leader can assign the recorder role to themselves or any team member.

The RCA charter identified the team leader and three team members. The team leader told the OIG of being the staff member who was most experienced in RCAs at the facility; "I am the one whose been doing RCAs at this medical center the longest." In spite of the team leader's experience, the OIG found no assigned recorder for the RCA. When asked, the team leader described recording some activities; however, upon the OIG's review, RCA documentation did not reflect key team actions, such as interviews, and meeting notes were sparse.

The OIG also found that although a team leader was designated on the charter, an SME was not identified. The patient safety manager who drafted the charter could not recall details regarding the RCA's charter. The QSV chief reviewed the charter and identified a team member as the SME; however, the team member told the OIG of having no expertise with the RCA focus area. Through a review of emails between the team leader and the identified SME team member, the OIG found the team member informed the team leader of not having expertise and the team leader responded "[n]one of the members are experts on the subject."

The OIG concluded that the RCA team's composition did not meet VHA requirements. The RCA team did not include a team leader who ensured the team's alignment with required RCA components such as an assigned recorder. The team leader not assigning a team member as a recorder may have contributed to the lack of RCA documentation. The OIG opined that if a recorder was assigned, key team activities would have likely been documented. Further, the team did not include an SME who was well versed in the RCA focus area. Without an SME, knowledge gaps remained about the focus area under review.

RCA Process

Proper execution of RCA steps is a vital component of an RCA's credibility and occurs in part through the team's (1) initial understanding of the event, (2) identification of knowledge gaps through triage questions, and (3) analysis of information through tools such as final flow and cause-and-effect diagrams.[32]

The OIG determined the RCA team improperly executed RCA steps that may have precluded a thorough examination of the event:

- Initial triage questions were not applied during the team's analysis, resulting in knowledge gaps.

[32] NCPS, *Guide to Performing Root Cause Analysis*, version 14. The guide states that a final flow diagram is a "graphic representation of the event … progressing in step wise fashion from the first known relevant fact through the final known relevant fact" representing a complete understanding of the event. A cause-and-effect diagram "is a systemic method of determining causal links … working backwards with 'caused by' statements for specific actions and conditions until a reasonable preceding cause or contributing factor can no longer be identified."

- Inaccurate information, documented in the initial understanding and during the RCA process, remained in the final flow and cause-and-effect diagrams, which contributed to a flawed analysis and conclusion.

The OIG has confidence that if the RCA team had properly executed the RCA steps, more likely than not, the team would have identified the system vulnerabilities discussed previously in this report that contributed to the event's occurrence:

- Facilitation of the onboarding process of the subject physician as a pulmonary disease and critical care medicine fellow at the facility, even though the fellowship had ended years prior.
- Authorization of VA computer access for the subject physician when no justification for access existed.
- Inclusion of the subject physician in an ICU coverage pool without verification of employment status or credentialing and privileging.

Timeliness

The completion of an RCA "allow[s] for more accurate and rapid assessment of potential and actual causes of patient harm" with a goal of eliminating or correcting the root cause or contributing factors to "prevent the problem from reoccurring."[33] Medical center directors are responsible for ensuring RCAs are completed within 45 calendar days from the day facility leaders are aware that an RCA is needed.[34]

The Facility Director became aware of the event six days after it occurred and determined the need for an RCA three days later; however, the RCA was not chartered for approximately 10 weeks. Further, the RCA was not completed until 126 days after facility leaders decided an RCA should be done.[35] The QSV chief told the OIG the RCA was intentionally delayed because of an increase in patient safety staff workload due to multiple concurrent RCAs. The Facility Director could not recall why the RCA was delayed but thought the number of concurrent RCAs may have contributed.

The QSV chief told the OIG that at the time the RCA was conducted, there had been "a huge backlog" of RCAs pending completion due to staff vacancies but as of September 2024, the

[33] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[34] VHA Directive 1050.01; VHA Directive 1050.01(1). The directives contain the same or similar information related to facility director RCA responsibilities.

[35] The former Chief of Staff told the OIG prior to the RCA's charter the intermittent ICU physician responsible for managing the coverage pool was instructed to stop the scheduling practice.

backlog had been resolved. The Facility Director and the PSO reported awareness of the backlog and attributed the delays to patient safety staffing but said timeliness had improved.[36]

Due to concerns of RCA timeliness deficiencies, the OIG examined facility RCA data from October 1, 2023, through September 30, 2024.[37] The OIG found that eight of the nine RCAs reviewed did not meet the 45-day completion requirement.

The OIG concluded the RCA for the event was not completed within the 45-day time frame as policy required. Further the OIG identified this deficiency as a pattern. Failing to complete RCAs according to VHA established time frames may prolong the identification and correction of patient safety risks.

Accurate Root Cause Analysis

Root cause statements "synthesize the RCA team's findings," and "identify what system vulnerabilities contributed" to the event.[38] The root cause statement should lead the team to an appropriate action plan and allow a person unfamiliar with the RCA to understand what occurred.[39] Root cause statements are to be written in a way that "[c]learly show[s] the 'cause and effect' relationship" using "specific and accurate descriptors for what occurred."[40] VHA asserts that structuring root cause statements this way "leaves little doubt regarding which and where corrective actions need to be applied."[41]

The OIG reviewed the RCA's root cause statement and found it contained inaccurate information and did not identify underlying system vulnerabilities or the root cause of the event. The OIG is concerned that when staff fail to identify the root cause of a patient safety event, the underlying system vulnerabilities that put patients at risk are also not identified.

During interviews, facility leaders told the OIG that the RCA's root cause statement did not identify system vulnerabilities that contributed to the event. Specifically, the QSV chief said the questions posed in the RCA team's initial understanding of the event were not answered. The Chief of Staff told the OIG of concerns that the team did not determine the root cause. When the OIG asked why the team was unable to meet these criteria, the Chief of Staff commented that the

[36] The PSO is a VISN staff member who serves "as the principal advisor" for VISN facilities' patient safety programs and is responsible for "[e]nsuring actions are taken to review, address and correct deficiencies, when identified." VHA Directive 1050.01; VHA Directive 1050.01(1). The directives contain the same or similar information related to VISN PSO responsibilities unless otherwise noted.

[37] The PSO provided facility RCA data to the OIG for review. The OIG did not independently verify VHA data for accuracy or completeness.

[38] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[39] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[40] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[41] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

team lacked an understanding of the event, and the team did not consist of individuals with knowledge of the topic.

Further, the Chief of Staff told the OIG of reporting these concerns to the team leader at the RCA presentation with a recommendation that the team "go back to the drawing board."[42] The Chief of Staff also recalled discussing these concerns with the Facility Director and shared that the Facility Director agreed the team did not identify the root cause of the event. During an OIG interview, the Facility Director could not recall a conversation with the Chief of Staff; however, the Facility Director recalled telling a former facility leader "our awareness has been raised but I just feel like there's maybe some other things we need to be looking at as well." Based on the Facility Director's statement, the OIG questioned why the Facility Director concurred with the RCA team's conclusion.

Director's Concurrence

RCA teams obtain RCA concurrence from a medical center director; this occurs following a presentation to facility leaders about the RCA, including associated findings and recommended actions.[43] Following the presentation, the medical center director can concur with the team's findings and subsequent action plan by signing an RCA concurrence sheet, which "authenticates the completion of the RCA."[44] When the medical center director does not concur, the team "should meet again to decide if there is another action that may address the root cause or contributing factor."[45] If disagreement persists, the RCA concurrence sheet is completed, indicating the medical center director's nonconcurrence.[46]

The Facility Director reported being on leave the day of the RCA presentation and told the OIG that when an RCA presentation is missed, typical actions include discussing the presentation with the acting director and reviewing the presentation slides. The acting director reported attending the presentation but neither the acting director nor the Facility Director recalled discussing this RCA. Therefore, the OIG surmised that the Facility Director's decision to concur with the RCA findings and action plan was based on a review of the presentation slides.

The OIG found the slides did not include sufficient information to understand how the subject physician provided care in the ICU or how the identified root cause and subsequent action plan would prevent a similar event. The OIG would expect that the insufficient information included

[42] The OIG was unable to determine what actions the RCA team took, if any, based on the Chief of Staff's concerns. While the team leader told the OIG additional team meetings occurred following the presentation to address the Chief of Staff's concerns, there was no documentation of the meetings, and the team leader could not recall further discussions.

[43] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[44] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[45] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[46] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

in the presentation slides coupled with the Facility Director's reservations about the RCA's analysis and conclusions would preclude concurrence. The Facility Director could not recall specific details on what contributed to the decision to concur.

The OIG has concerns that despite having reservations about the RCA's analysis and conclusion, the Facility Director signed the concurrence sheet rather than opting to not concur. The Facility Director's concurrence weakened the effectiveness of the RCA process and resulted in the root causes that contributed to the event remaining unaddressed.

Additional Concurrence Step

During interviews with patient safety and former patient safety staff (patient safety staff), the OIG learned that RCA teams use an additional concurrence step that is not outlined in VHA guidance.[47] The RCA team

- contacts supervisors or leaders tasked with implementing an RCA recommendation,
- shares general information about the RCA, and
- obtains the supervisor or leader's feedback and agreement with the recommendation before the RCA presentation to facility leaders and the director's decision on concurrence.[48]

Patient safety staff told the OIG that VISN and facility leaders encouraged this extra step to obtain "input" or "buy-in" from leaders of the RCA focus area. This step occurs before presenting RCA findings and recommendations to the Facility Director at the final RCA presentation. The OIG is concerned about the vulnerabilities that exist related to the information that can and cannot be shared during this step. While there may be value in this process, an RCA is a protected quality management activity under 38 U.S.C. §5705; associated documents including identifying information contained in the RCA are protected and confidential and, therefore, cannot be shared.[49] An additional vulnerability that the OIG identified is the potential for service line leaders to influence the trajectory of RCA findings.

The OIG interviewed facility, VISN, and national patient safety leaders about the additional concurrence step. The QSV chief told the OIG of an expectation that RCA teams include the additional step when conducting RCAs and stated, "they're [RCA teams are] not sharing the

[47] NCPS, *Guide to Performing Root Cause Analysis*, version 14.

[48] The leaders contacted had oversight of the subject RCA focus area (e.g., service line, unit, ward, specialty). Staff learned the additional step through a variety of ways, which included on the job and National Center for Patient Safety training and consultation with the VISN PSO.

[49] 38 U.S.C. § 5705, Confidentiality of medical quality assurance records; VHA Directive 1320, *Quality Management and Patient Safety Activities That Can Generate Confidential Records and Documents*, July 10, 2020. Identifying information includes names or position titles and locations. NCPS, *NCPS Guidance for De-identifying RCAs*, June 20, 2024, NCPS, *Guide to Performing Root Cause Analysis*, version 14.

event and all the information, they're just asking about a process." The QSV chief also said that if the RCA team and the supervisor or leader tasked with implementing RCA recommendations did not agree with the recommendations, the RCA team could still move forward and present the recommendations to the Facility Director. The QSV chief was unaware that service line leaders disagreeing with a recommendation could impede the process.

The Facility Director told the OIG of an expectation that the RCA team obtains "buy-in from the stakeholders" before the final presentation but did not know RCA teams were seeking agreement from leaders tasked with implementing recommendations. The Facility Director expressed concerns only if the additional step breeched RCA confidentiality or team recommendations were adjusted based on fear of retaliation.

The PSO reported familiarity with the additional step and recalled providing consultation to patient safety staff when the use of the extra step was recommended, but not required, for the RCA team to resolve challenges with developing recommendations. The PSO told the OIG of not having concerns about RCA teams obtaining "buy-in" from service line leaders but would have concerns if the service line leaders "dictate what the [RCA] action would be."

A National Center for Patient Safety leader reported that while teams discussing recommended actions with a "service line leader or someone who is going to be responsible for implementing one of the actions" is acceptable, the additional step is not required and agreement is not needed before the RCA is presented to the medical center director.[50] The National Center for Patient Safety leader reported RCA teams should not change recommendations based on "a service line leader's pushback" and that specific RCA information should not be shared.

The OIG found facility patient safety staff misinterpreted the step and believed that leaders of the RCA focus area must concur with the recommendations before the final RCA presentation. When asked about the use of the additional step, the RCA team leader told the OIG of communicating RCA results to "anyone who is affected by the suggestions the RCA team has" prior to the final RCA presentation. Concerningly, the OIG found that email communication seeking agreement with RCA recommendations from a team member to RCA focus area staff contained confidential information. Due to finding information breaches in the RCA process, the OIG shared this finding with facility and VISN leaders at the conclusion of the site visit.

The OIG determined national, VISN, and facility leaders encouraged this step, however, failed to recognize patient safety staff were seeking full agreement with recommendations, rather than general buy-in, before moving RCA actions forward to the Facility Director. This extra step

[50] The Chief of Staff provided the OIG with training materials from a recent National Center for Patient Safety RCA training. The training slides included instruction that "PSM [patient safety manager] should have already met with any Chiefs who will be responsible for actions (process owner buy-in). The first time they hear about it shouldn't be at the Close-Out Briefing [team presentation to the director]." This training was provided to the Southeastern States Network Consortium, which includes VISNs 6, 7, 8, 9, and 16.

could: compromise the integrity of the RCA process with potential undue influence; breach confidentiality; and contribute to delays.

The OIG also identified a similar practice during two other healthcare inspections.[51] The OIG is concerned that this additional step is being implemented at other VHA facilities.

Conclusion

The OIG substantiated that the subject physician provided patient care for three hours in the facility's ICU with attending physician oversight. Failure to follow the VHA trainee onboarding process and lack of oversight of physician coverage for the ICU at the facility contributed to this event. The coordinator facilitated the VHA trainee onboarding process before receiving the required verification letter, resulting in the improper onboarding of the subject physician. Additionally, the chief of medicine failed to ensure a process was implemented to verify that physicians in the ICU coverage pool were credentialed and privileged at the facility before being scheduled and providing patient care. The subject physician was a pulmonary disease and critical care medicine fellow from the academic affiliate but was not independently credentialed and privileged at the facility as a provider.

The Facility Director chartered an RCA following awareness of the event. Deficiencies with the RCA teams' use of the RCA process left patient safety vulnerabilities unresolved and how the subject physician was onboarded as a trainee or provided care in the facility's ICU was not explored. The OIG determined the RCA team did not follow VHA-required guidelines and identified concerns with the reliability of the RCA team's assessment and conclusion. Contributing factors included the composition of the RCA team and that initial triage questions were not used during analysis. Further, the RCA as well as other facility RCAs were not completed within the required 45-day time frame, which may have delayed the identification and correction of patient safety risks.

The RCA's root cause statement contained inaccurate information and did not identify underlying system vulnerabilities, or the root cause of the event. Despite concerns from the Chief of Staff and Facility Director that the RCA failed to identify the root cause of the event, the Facility Director concurred with the RCA team's conclusion. When a medical center director concurs with an RCA team's conclusion that does not address the issue, the effectiveness of the RCA process is weakened and results in root causes remaining unaddressed.

The OIG also learned that an additional RCA concurrence step, not outlined in VHA guidance, is used at the facility. This step created vulnerabilities related to breaching RCA confidentiality and service line leaders influence over RCA findings, which compromises the integrity of the RCA

[51] The previous inspections were at the Tuscaloosa VA Medical Center in Alabama and the VA Maine Healthcare System in Augusta and are located within different VISNs.

process. The OIG identified a similar practice during two other healthcare inspections and is concerned that this additional step is being implemented at other VHA facilities.

Recommendations 1–4

1. The Overton Brooks VA Medical Center Director reviews and monitors compliance with Veterans Health Administration health professions trainee onboarding requirements, and takes action as indicated.

2. The Overton Brooks VA Medical Center Director makes certain that oversight of the intensive care unit physician credentialing and privileging process is completed prior to physicians being scheduled and providing patient care, and monitors compliance.

3. The Overton Brooks VA Medical Center Director ensures root cause analyses are completed according to Veterans Health Administration policy including team composition, root cause analysis process steps, and timeliness.

4. The Under Secretary for Health evaluates the additional root cause analysis concurrence step used within Veterans Health Administration medical centers to ensure alignment with National Center for Patient Safety guidance, and takes action as indicated.[52]

[52] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: March 19, 2025

From: Acting Under Secretary for Health (10)

Subj: Healthcare Inspection—Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana

To: Acting Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG draft report, Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana.

2. The Veterans Health Administration (VHA) concurs with recommendation 4 made to the Under Secretary for Health and provides an action plan in the attachment. The Veterans Integrated Service Network 16 concurs with recommendations 1-3 and provides action plans in a separate response.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on March 20, 2025.]

Office of the Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)
Under Secretary for Health Action Plan

OIG Draft Report - Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana (2024-01566-HI-1461)

Recommendation 4: The Under Secretary for Health evaluates the additional root cause analysis concurrence step used within Veterans Health Administration medical centers to ensure alignment with National Center for Patient Safety guidance, and takes action as indicated.

VHA Comments: Concur. The VHA National Center for Patient Safety (NCPS) will review and provide guidance to clarify the additional Root Cause Analysis (RCA) concurrence step used during action plan development. This will be updated in the RCA training materials and in the RCA Guidebook. NCPS will provide any updates and further clarity on the action plan development concurrence process in upcoming patient safety communities of practice calls.

Target Completion Date: June 2025

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 11, 2025

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

Subj: Healthcare Inspection—Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana

To: Director, Office of Healthcare Inspections (54HL06)
Director, GAO/OIG Accountability Liaison Office (VHA 10OICGOALAction)

1. We appreciate the opportunity to review and comment on the Office of Inspector General (OIG) report, Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana.

2. I reviewed and concurred with the recommendations and the action plans submitted by the Overton Brooks VA Medical Center. We remain committed to ensuring our Veterans receive exceptional care and Veterans Integrated Services Network (VISN) 16 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.

3. I would like to thank the OIG for their thorough review, and if there are any questions regarding responses or additional information required, please contact the VISN 16 Quality Management Officer.

(*Original signed by*:)

John Areno
For
Skye McDougall, PhD
Network Director

[OIG comment: The OIG received the above memorandum from VHA on March 20, 2025.]

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 10, 2025

From: Director, Overton Brooks VA Medical Center (667/00)

Subj: Healthcare Inspection—Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana

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

1. Thank you for the opportunity to review and respond to the Office of Inspector General's (OIG) draft report, Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana.

2. The Overton Brooks VA Medical Center concurs with the recommendations and submits the attached action plan. The findings outlined in the OIG report reflect a thorough evaluation.

3. Should you need further information, contact the facility Chief of Quality & Patient Safety.

(*Original signed by*:)

Crockett, Richard L.
Medical Center Director

[OIG comment: The OIG received the above memorandum from VHA on March 20, 2025.]

Facility Director Response

Recommendation 1

The Overton Brooks VA Medical Center Director reviews and monitors compliance with Veterans Health Administration health professions trainee onboarding requirements, and takes action as indicated.

_X _Concur

____Nonconcur

Target date for completion: August 2025

Director Comments

The Veterans Health Administration (VHA) developed the new onboarding system, the Account Provision/Deprovisioning System (APDS), which was implemented at the Overton Brooks VA Medical Center in February 2024. This process requires using a Trainee Qualifications and Credentials Verification Letter (TQCVL) Memo and List provided by the Affiliate to initiate the in-processing of residents, fellows, health professional trainees, and students. The Designated Education Officer will implement monthly reviews of the onboarding process, including a tracking system to monitor compliance with VHA health professions trainee onboarding requirements. Tracking and compliance will be reported at the facility Medical Executive Board (MEB) meeting along with applicable corrective actions.

Recommendation 2

The Overton Brooks VA Medical Center Director makes certain that oversight of the intensive care unit physician credentialing and privileging process is completed prior to physicians being scheduled and providing patient care, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: April 2025

Director Comments

In collaboration with Chief of Staff, the Medical Center Director will ensure a new Standard Operating Procedure for the utilization and scheduling of fee-basis or intermittent physicians in the Intensive Care Unit will be written and approved. Schedules will be reviewed and approved by the Chief of Medicine Service (or designee) to ensure that all physicians and providers are appropriately privileged prior to their scheduled shifts. This review will be documented monthly on a tracking form. Compliance will be tracked through the MEB until closed.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The Overton Brooks VA Medical Center Director ensures root cause analyses are completed according to Veterans Health Administration policy including team composition, root cause analysis process steps, and timeliness.

_X _Concur

____Nonconcur

Target date for completion: November 2024

Director Comments

The Medical Center Director will ensure root cause analyses (RCAs) are completed in accordance with VHA policy, which includes team composition, RCA process steps, and timeliness.

Quality Management leadership has implemented several notable changes to support compliance, such as enhancing the RCA team training, increasing RCA status reporting, and providing additional staff support. RCA team training has been reviewed, consolidated, and revised. This training occurs during the first RCA team meeting. As of November of 2024, the facility is staffed with two full-time Patient Safety Managers and one Quality Management Specialist that is trained and can assist if needed. These efforts have resulted in compliance with RCA required timeframes and improvement in national RCA quality assessment scoring. The Quality Assessment Tool (QAT) measures RCAs by scoring several quality elements such as team composition, final flow and understanding, contributing factor statements, action statements, and outcome measures. At the time of this event, the QAT was rated as fair by the National Center for Patient Safety. Since this event, our score has increased from fair to very good or excellent for the period between fiscal year (FY) 2023 quarter three, and FY 2024, quarter four. Timeliness to complete RCAs has also shown improvement. The total days to completion of our last three RCAs are now at forty-five days or less.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

OIG Contact and Staff Acknowledgments

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