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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah

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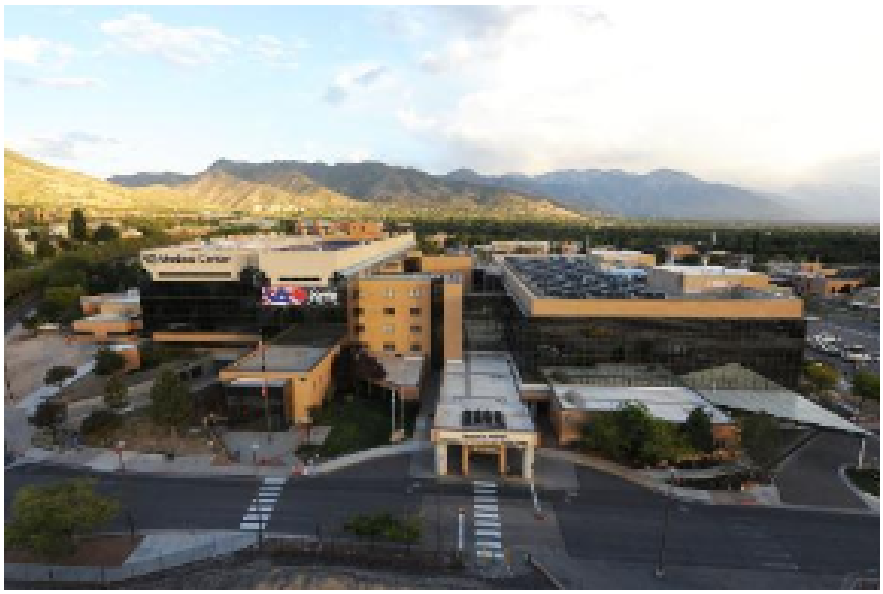

Figure 1. *George E. Wahlen VA Medical Center of the VA Salt Lake City Health Care System in Utah.*

Source: https://www.va.gov/salt-lake-city-health-care/ (*accessed January 25, 2023*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Salt Lake City Health Care System, which includes the George E. Wahlen VA Medical Center in Salt Lake City and multiple outpatient clinics in Idaho, Nevada, and Utah. 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 VA Salt Lake City Health Care System during the week of February 27, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

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

health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 23.

VA Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 26–27, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Salt Lake City Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

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

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

Methodology

The VA Salt Lake City Health Care System includes the George E. Wahlen VA Medical Center in Salt Lake City and multiple outpatient clinics in Idaho, Nevada, and Utah. General information about the healthcare system can be found in appendix B.

The OIG inspected the VA Salt Lake City Health Care System during the week of February 27, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The 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 VA Salt Lake City Health Care System occurred in December 2020. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in May 2022.

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

Results and Recommendations

Leadership and Organizational Risks

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

To assess this healthcare system's leadership and risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant 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 ADPCS position had been vacant for one month, and the Deputy ADPCS was covering the role in an acting capacity. The Director, assigned on March 13, 2022, was the most tenured leader. The Assistant Director and Associate Director had been in their positions since July 31 and August 28, 2022, respectively. The Chief of Staff joined the team on February 12, 2023.

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

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

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

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, acting 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 healthcare system's fiscal year (FY) 2022 annual medical care budget of $811,321,002 had increased by over 9 percent compared to the previous year's budget of $743,057,692.[10] The Director and acting ADPCS reported using funds to maintain the facility infrastructure due to its age and hire additional employees.

Human Resources Modernization

Prior to FY 2019, the Veterans Health Administration (VHA) human resources department was mostly a "decentralized, facility-based service" that was often unique to the facility.[11] VHA identified challenges with the decentralized model including time-to-hire delays, non-standardized processes, and resource constraints. To address these issues, VHA began the process of human resources modernization, which included "consolidating human resource functions from more than 140 local facilities to a shared services model" under each VISN.[12]

When asked to describe the impact human resources modernization processes had on the system's occupational shortages, the Director identified two outpatient clinics in Utah, the St. George VA Clinic and the Ogden VA Clinic, that were no longer accepting new or transferring primary care patients as of June 14 and August 23, 2022, respectively, due to provider and nurse vacancies. The Chief of Staff stated that two of the six operating rooms had closed due to staffing shortages, specifically for surgical technicians and nurses, and that patients needing surgery were sent to community hospitals for care.

The Senior Strategic Business Partner stated that since the COVID-19 pandemic, the average time-to-hire a new employee had increased from 81.9 to 119.3 days, and the facility had a loss of about 20 percent of registered and licensed practical nurses, believing this was due to competition from community hospitals. According to the Senior Strategic Business Partner and Associate Director, efforts to improve staffing shortages included holding local job fairs; offering recruitment, retention, and relocation incentives for nurses and special salary rates for medical support assistants; and ensuring staff promptly complete new employee physical exams and drug tests.

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

[11] "VHA Modernization: Develop Responsive Shared Services," VA Insider, accessed February 10, 2023, https://vaww.insider.va.gov/vha-modernization-develop-responsive-shared-services/. (This website is not publicly accessible.)

[12] "VHA Modernization: Develop Responsive Shared Services," VA Insider.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] 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.[14] Table 1 provides relevant survey results for VHA and the healthcare system over time.

The healthcare system's survey scores were higher than VHA averages in FY 2020 and remained the same in FYs 2021 and 2022. The Chief of Staff reported employees had multiple ways of reporting concerns and that all leaders tell employees if they see something, to say something. In addition, the Chief of Staff stated that when an adverse event happens, staff focus on process issues.

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
VA Salt Lake City Health Care System	3.9	3.9	3.9

Source: VA All Employee Survey (accessed November 8, 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.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from

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

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

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

FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

Inpatient, primary care, and specialty care survey scores were consistently higher than VHA averages for all three FYs, which imply patients were generally satisfied with the care they received compared to patients at other VHA facilities. The Chief of Staff explained leaders had focused on inpatient experiences by improving food choices and sleeping conditions. To further increase positive patient experiences in inpatient and outpatient settings, the leaders discussed using survey data to develop action plans when problematic trends appeared and ensuring patient advocates resolved reported issues. The acting ADPCS reported the recently hired primary care manager has had a positive impact on provider and social worker collaboration in primary care settings, and the Specialty Care Chief Nurse has been reviewing current processes for opportunities to improve patient experiences. However, the Director acknowledged having concerns about the potential negative effects of staffing shortages and employee burnout on patient experiences.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	71.9	69.7	73.9	68.9	70.8
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	84.9	81.9	82.3	81.7	85.5
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	85.0	83.3	86.5	83.1	84.0

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8, 2022, for primary and specialty care and December 14, 2022, for inpatient).

*****The response average is the percent of "Definitely yes" responses.*

†*The response average is the percent of "Very satisfied" and "Satisfied" responses.*

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[16] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[17] 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.[18]

"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)."[19] 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."[20] 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."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[22]

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[16] Frankel et al., *A Framework for Safe, Reliable, and Effective Care;* "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 7, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[17] 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.

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

[19] 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.

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

[21] VHA Directive 1004.08.

[22] 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.)

System leaders stated they have a robust patient safety reporting process that includes using the Joint Patient Safety Reporting system.[23] The Director reported reviewing patient safety events daily with the Patient Safety Manager. The acting ADPCS added that a nurse is on duty 24 hours a day, 7 days a week, and is responsible for notifying the executive leader on call when a patient safety event occurs after normal business hours.

The OIG requested a list of sentinel events and institutional disclosures that occurred during FY 2022 and reviewed the information staff provided. For sentinel events, the Chief of Staff described discussing the incidents with the Patient Safety Manager to determine their cause and next steps required, such as a root cause analysis.[24] The Director said the Quality Safety Values Board tracked root cause analyses and other patient safety improvement projects, and the Patient Safety Manager is responsible for trending the data to identify vulnerabilities and recommend process improvements.

The Chief of Staff explained that leaders review patient safety events and complete an institutional disclosure when required. The acting ADPCS reported being involved in the institutional disclosure process to answer nursing-related questions.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[23] The Joint Patient Safety Reporting system is a web-based application used by VHA staff to report patient safety events. "VHA National Center for Patient Safety Frequently Asked Questions," Department of Veterans Affairs, accessed December 21, 2022, https://www.patientsafety.va.gov/about/faqs.asp.

[24] 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).

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[25] 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.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[27]

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.[28] 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.[29]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[30] 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."[31] 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.[32]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed four deaths that occurred within 24 hours of inpatient admission during FY 2022.[33]

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[27] VHA Directive 1100.16.

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

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

[30] 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.

[31] VHA Directive 1190.

[32] VHA Directive 1190.

[33] Facility staff told the OIG there were no suicides within seven days of discharge from an inpatient mental health unit.

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."[34] 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."[35]

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.[36] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[37]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[38]

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.[39] 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

[34] 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).

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[40]

The OIG interviewed key managers and selected and reviewed the privileging folders of 28 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires the chief of staff to ensure FPPE criteria are "defined in advance, using objective criteria accepted by the LIP."[41] The OIG found that four privileging folders reviewed lacked evidence LIPs were aware of FPPE criteria before the service chiefs initiated the process. When service chiefs do not communicate evaluation criteria, LIPs could misunderstand FPPE expectations. The interim Chief, Primary Care and the chiefs for medicine and surgery services attributed the noncompliance to being unaware of the requirement. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

VHA requires service chiefs to report FPPE results to an executive committee of the medical staff for consideration in recommending privileges.[42] The OIG found that four privileging folders reviewed lacked evidence service chiefs reported the FPPE results to an executive committee for consideration in the LIPs' initial privileging. Failure to report FPPE results to the committee resulted in incomplete data to support its recommendations for LIPs' clinical privileges. The previous interim Chief of Staff said the Professional Standards Board members only discussed FPPEs with deficiencies. The Chief, Surgery Service acknowledged being unaware of the need to report all FPPE results to an executive committee of medical staff.

Recommendation 1

1. The Chief of Staff ensures service chiefs report Focused Professional Practice Evaluation results to an executive committee of the medical staff for consideration in privileging recommendations.

[40] 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.

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

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

Healthcare system concurred.

Target date for completion: August 1, 2024

Healthcare system response: The Chief of Staff evaluated reasons for noncompliance and found no additional reasons for noncompliance. The medical center clinical service chiefs will ensure results of Focused Professional Practice Evaluations are discussed at the Professional Standards Board and reported to the Executive Committee of the Medical Staff for consideration in privileging recommendations.

Effective March 27, 2023, the Professional Standards Board agenda reflects all pending Focused Professional Practice Evaluations, which are identified by service and due date. Confirmation of completed Focused Professional Practice Evaluations are detailed on the minutes referencing completion, identifying any issues or not, and recommendation for transitioning to the Ongoing Professional Practice Evaluation cycle. Additionally, it is noted the recommendation to move from Focused Professional Practice Evaluation to Ongoing Professional Practice Evaluation is forwarded to the Executive Committee of the Medical Staff to review and concur.

Compliance Monitor: By August 1, 2024, the facility will achieve 90 percent or greater compliance with the completion of timely Focused Professional Practice Evaluations for two consecutive quarters. The numerator will be the number of completed Focused Professional Practice Evaluations discussed and documented at the Professional Standards Board for consideration in privileging recommendations each month. The denominator will be the total number of Focused Professional Practice Evaluations due each month.

The Credentialing and Privileging Supervisor will report the compliance rate of Focused Professional Practice Evaluations monthly to the Executive Committee of Medical Staff, which is chaired by the Chief of Staff until 90 percent compliance is achieved and sustained for two consecutive quarters.

Environment of Care

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

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated.[45]

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

- Acute Medical Inpatient Unit (2 East)
- Emergency Department
- Inpatient Psychiatry Unit
- Intensive care unit (medical/surgical)
- Primary care clinic (Blue)
- Women's Health Clinic

Environment of Care Findings and Recommendations

VHA requires staff to conduct environment of care inspections at least "twice per fiscal year in all areas where patient care is delivered."[46] The OIG reviewed FY 2022 environment of care inspection reports and found that staff did not inspect all clinical areas as required. Failure to inspect clinical areas could result in staffs' lack of proactive identification and correction of unsafe conditions. The Occupational Safety Manager reported that although staff did not inspect

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

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

[45] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.)

[46] VHA Directive 1608.

all areas during FY 2022, they inspected them within 12-calendar months from the last inspection.

Recommendation 2

2. The Director ensures staff conduct environment of care inspections in patient care areas as required.

Healthcare system concurred.

Target date for completion: August 1, 2024

Healthcare system response: The Assistant Director reviewed the recommendation and did not identify additional reasons for noncompliance. The Assistant Director will ensure that the facility staff complete and document environment of care inspections per the approved annual schedule. The approved annual environment of care inspection schedule is formulated to ensure that building zones that contain patient care areas are rounded on every six months, regardless of type of functional patient care unit. The Chief of Occupational Health and Safety will be responsible for tracking and monitoring that environmental care rounds are completed each month according to schedule using Performance Logic.

Compliance Monitor: By August 1, 2024, the facility will achieve 90 percent or greater compliance with the completion of environment of care inspections in patient care areas for two consecutive quarters. The numerator will be the number of completed environment of care inspections in patient care areas each month and the denominator will be the total number of patient care areas due for inspection each month.

The Chief of Occupational Health and Safety will report the compliance rate with meeting scheduled inspections monthly to the Safety Management Committee, which is chaired by the Assistant Director until 90 percent compliance is achieved and sustained for two consecutive quarters.

VHA requires staff to perform systematic environmental assessments using the Mental Health Environment of Care Checklist to identify and address risks for patients under treatment.[47] The Mental Health Environment of Care Checklist states staff should test all panic alarms on the Inpatient Psychiatry Unit at least quarterly and record testing in a log, including police response times.[48] The OIG requested evidence of panic alarm testing and monitoring of police response times from October through December 2022; however, staff did not provide the requested information. Failure to test panic alarms and monitor police response times may put patients,

[47] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

[48] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," October 30, 2022.

visitors, and staff at risk in the event of an actual emergency. The Physical Security, Police Services and Chief of Police reported that police tested panic alarms in March, June, August, and October 2022; however, the Physical Security, Police Services acknowledged not monitoring the police response times. In addition, the Patient Safety Manager told the OIG that the Mental Health Environment of Care Checklist states that panic alarm testing and monitoring of police response times *should* be done and is therefore not required.

Recommendation 3

3. The Director ensures staff test panic alarms in the Inpatient Psychiatry Unit at least quarterly and record testing in a log, including police response times.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Director reviewed the recommendation and did not identify additional reasons for noncompliance. The Chief of Mental Health, Chief of Police, and Mental Health Chief Nurse will ensure that staff will test all panic alarms on the Inpatient Psychiatry Unit at least quarterly and record testing in a log, including police response times.

Compliance Monitor: By September 30, 2024, the Inpatient Psychiatry Unit will achieve a 90 percent or greater compliance with the completion of quarterly panic alarm testing on Inpatient Psychiatry Unit for two consecutive quarters. The numerator is the number of panic alarms tested in the Inpatient Psychiatry Unit with documented police response time each quarter. The denominator is the number of panic alarms tested in the Inpatient Psychiatry Unit each quarter.

The Inpatient Psychiatry Unit Nurse Manager in collaboration with the Inpatient Psychiatry Medical Director will be responsible for tracking and monitoring the quarterly panic alarm testing, including documentation of VA Police response times. The Chief of Police or designee will report the testing results quarterly to the Safety Management Committee, which is chaired by the Assistant Director until 90 percent compliance is achieved and sustained for two consecutive quarters.

The Mental Health Environment of Care Checklist states that staff must test all over-the-door alarms on corridor doors leading to patients' sleeping rooms according to the manufacturer's guidelines to ensure proper functioning.[49] The manufacturer's guidelines for the healthcare system's installed devices recommend staff test each door alarm weekly and a contracted maintenance employee conducts an independent test annually. Staff did not provide evidence for either weekly alarm testing by employees or annual testing by the contractor. When staff fail to ensure door alarms are working properly, they may not be alerted when there is a patient

[49] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist."

emergency. The Patient Safety Manager reported staff overlooked over-the-door alarm testing when the Nurse Manager for the Inpatient Psychiatry Unit was temporarily reassigned to another position.

Recommendation 4

4. The Director ensures staff test over-the-door alarms in the Inpatient Psychiatry Unit per the manufacturer's recommendations.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Associate Director reviewed the recommendation and did not identify additional reasons for noncompliance. The Chief of Engineering will ensure that the over-the-door alarms in the Inpatient Psychiatry Unit are tested per the manufacturer's recommendations via a contracted service company. Given the high patient safety risks in an Inpatient Psychiatry Unit, the facility has chosen to ensure accuracy and completeness with the weekly testing by hiring a contractor to complete the weekly test, as well as the yearly recertification, as the facility noticed a higher caliber of testing with the contractor versus facility personnel due to the possibility of facility staff being distracted with patient care while testing the alarms.

On March 8, 2024, the Contractor began performing weekly testing and completed the yearly recertification of the over-the-door alarms. The contract representative who conducts the weekly checks will be different from the contract representative who will conduct the annual checks. The weekly report and yearly recertification will be provided to the Chief of Engineering and Inpatient Psychiatry Unit Nurse Manager via email. In addition, a verbal report will be given to the Charge Nurse of the outcome of the weekly test upon completion of the weekly testing. Any over-the-door alarm failures will be repaired by the contractor and the Charge Nurse will be notified immediately of the failure.

Compliance Monitor: By September 30, 2024, the facility will achieve 90 percent or greater compliance with the completion of weekly testing of the over-the-door alarms for two consecutive quarters. The numerator is the number of over the door alarms tested in the Inpatient Psychiatry Unit each week. The denominator is the total number of over-the-door alarms in the Inpatient Psychiatry Unit that require testing each week.

The Inpatient Psychiatry Unit Nurse Manager will report the compliance rate of the weekly over-the-door testing monthly to the Quality and Patient Safety Board, which is chaired by the Director until 90 percent compliance is achieved and sustained for two consecutive quarters.

The Joint Commission requires staff to ensure "interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided."[50] The OIG found a toilet bowl and sink with chipped paint in a patient's room in the Inpatient Psychiatry Unit. When paint is chipped, patients may remove it and harm themselves by swallowing it or cutting their skin. The Occupational Safety Manager stated the paint was a hard enamel that did not contain lead or pose any danger to patients.

Recommendation 5

5. The Director ensures staff keep interior spaces in the Inpatient Psychiatry Unit safe and suitable for care.

[50] The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, February 19, 2023.

Healthcare system concurred.

Target date for completion: October 1, 2024

Healthcare system response: The Director reviewed the recommendation and did not identify additional reasons for noncompliance. The Chief of Engineering in collaboration with the Chief of Occupational Health and Safety will ensure that the interior spaces in the Inpatient Psychiatry Unit are safe and suitable for care.

By March 1, 2024, a specialized Environment of Care checklist will be created in Performance Logic rounding tools. The checklist will be used for documenting, reporting, and identifying deficiencies, trends and actions taken, specifically in the Inpatient Psychiatry Unit. Items inspected will included evaluating for chipped paint, ligature risks, and any other identified patient safety concerns. The specialized Environment of Care checklist will be utilized by an Interdisciplinary Safety Inspection Team on a monthly basis. To comply with VA guidance, deficiencies will be closed within 14 business days or have an action plan submitted. The action plan will be reviewed and approved by Chief of Occupational Health and Safety.

By March 1, 2024, the Interdisciplinary Safety Inspection Team will be trained on the specialized Environment of Care Checklist and expectations for the inspection. The training will also include the utilization of Performance Logic.

By March 16, 2024, the toilet bowls and sinks within the Inpatient Psychiatry Unit will be assessed and repaired for any cracks or chips.

By March 31, 2024, the Inpatient Psychiatry Unit Nurse Manager in collaboration with the Inpatient Psychiatry Medical Director will educate the staff on the expectation of maintaining a safe and suitable environment for care within the Inpatient Psychiatry Unit.

Compliance Monitor: By October 1, 2024, the facility will achieve 90 percent or greater compliance with the completion of deficiencies (closed/action plan) noted on the specialized Environment of Care checklist within 14 days for two consecutive quarters. The numerator will be the number of completed (closed/action plan) environment of care deficiencies within 14 days each month and the denominator will be the total number of environment of care deficiencies documented in the specialized Environment of Care checklist each month.

The Chief of Occupational Health and Safety will report the compliance rate of completed deficiencies on the specialized Environment of Care checklist monthly to the Safety Management Committee, which is chaired by the Assistant Director until 90 percent compliance is achieved and sustained for two consecutive quarters.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[51] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[52] The suicide rate for veterans was higher than for nonveteran adults during 2020.[53] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[54]

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.[55] 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.[56]

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.[57]

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

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

[52] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed February 15, 2023.

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

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

[55] 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.)

[56] 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.)

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

Mental Health Findings and Recommendations

VHA requires providers to complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen. In addition, VHA states that providers should complete the evaluation on the same day as a positive suicide screen in all ambulatory care settings.[58] The OIG estimated that providers did not complete the evaluation after a positive screen for 94 (95% CI: 86 to 100) percent of patients, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[59] Furthermore, the OIG found that of the three evaluations completed, providers did not evaluate two patients for suicide risk within the same day as the positive screen. When providers fail to evaluate patients following a positive screen, they may miss opportunities to intervene and coordinate next steps in care. The interim Chief, Primary Care Services reported that providers and nursing staff vacancies led to a breakdown in communication of established processes and procedures.

Recommendation 6

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

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

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

Healthcare system concurred.

Target date for completion: October 1, 2024

Healthcare system response: The Chief of Staff evaluated reasons for noncompliance and ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

On November 2022, VA Salt Lake City Health Care System implemented a Suicide Prevention Champion initiative for staff to serve as champions and reinforce training in their respective service area based on identified need.

In May 2023, the Suicide Prevention Team and Mental Health staff provided new and refresher Champion training.

In June 2023, the Suicide Prevention Staff runs a Veterans Integrated System Technology Architecture report daily to identify positive Columbia Suicide Severity Rating Scale Screen and conducts a chart review for each Veteran. If a Comprehensive Suicide Risk Evaluation is not completed in the chart, Suicide Prevention Staff consult with relevant providers in order to facilitate assessment by the appropriate providers.

In October 2023, the Suicide Prevention Coordinator reviews the Comprehensive Suicide Risk Evaluation fallouts weekly in morning report with the Chief of Staff and Clinical Service Chiefs utilizing the Ambulatory Risk Identification dashboard.

Compliance Monitor: The facility will monitor Comprehensive Suicide Risk Evaluation metrics until 90 percent compliance is achieved and maintained for two consecutive quarters. The numerator is the number of patients who had a Comprehensive Suicide Risk Evaluation completed the same day as their positive suicide screen each month. The dominator is the total number of patients who had a positive suicide screen each month.

The Suicide Prevention Coordinator will report Comprehensive Suicide Risk Evaluation metric quarterly to the Healthcare Delivery Committee, which is chaired by the Chief of Staff.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines six 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 report Focused Professional Practice Evaluation results to an executive committee of the medical staff for consideration in privileging recommendations.
Environment of Care	• Staff conduct environment of care inspections in patient care areas as required. • Staff test panic alarms in the Inpatient Psychiatry Unit at least quarterly and record testing in a log, including police response times. • Staff test over-the-door alarms in the Inpatient Psychiatry Unit per the manufacturer's recommendations. • Staff keep interior spaces in the Inpatient Psychiatry Unit safe and suitable for care.
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 19.[1]

Table B.1. Profile for VA Salt Lake City Health Care System (660) (October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$759,878,707	$743,057,692	$811,321,002
Number of:			
• Unique patients	67,781	74,537	82,214
• Outpatient visits	631,303	703,109	696,336
• Unique employees§	2,432	2,566	2,356
Type and number of operating beds:			
• Domiciliary	15	23	11
• Medicine	45	45	45
• Mental health	30	30	30
• Rehabilitation medicine	3	5	5
• Surgery	21	22	22
Average daily census:			
• Domiciliary	11	10	9
• Medicine	30	33	33
• Mental health	22	18	17
• Rehabilitation medicine	3	3	4

[1] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census, cont.:			
• Surgery	8	8	6

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 16, 2024

From: Director, VA Rocky Mountain Network (10N19)

Subj: Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah

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

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

1. I have reviewed the findings within the Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah draft report. I concur with the findings of the review.
2. I concur with the facility plans of corrective actions and target dates.
3. I would like to thank the OIG Inspection team for a thorough review of the VA Salt Lake City Health Care System in Salt Lake City, Utah.

(Original signed by:)

Sunaina Kumar-Giebel
Director, Rocky Mountain Network

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: February 8, 2024

From: Director, VA Salt Lake City Health Care System (660)

Subj: Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah

To: Director, VA Rocky Mountain Network (10N19)

I have reviewed the findings within the Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah. I agree with the findings of the review.

The plan of corrective actions and target dates have been established.

(Original signed by:)

Angela D. Williams, Pharm.D., M.S., VHA-CM
Director, VA Salt Lake City Health Care System

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Rowena Jumamoy, MSN, RN, Team Leader Rachel Agbi, DBA, MSN Ayesha Callaway, MSN, RN Patricia Calvin, MBA, RN Carolyn McKay, LCSW
Other Contributors	Alicia Castillo-Flores, MBA, MPH Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Erika Terrazas, MS Elizabeth Whidden, MS, APRN Jarvis Yu, MS

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