



# US DEPARTMENT OF VETERANS AFFAIRS **OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

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## **VETERANS HEALTH ADMINISTRATION**

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# **Comprehensive Healthcare Inspection of the Iowa City VA Health Care System in Iowa**

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**Figure 1.** Iowa City VA Medical Center of the Iowa City VA Health Care System in Iowa.

Source: <https://www.va.gov/iowa-city-health-care/locations/>.

## Abbreviations

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



## Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Iowa City VA Health Care System, which includes the Iowa City VA Medical Center and multiple outpatient clinics in Illinois and Iowa. 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 emergency department and urgent care center suicide prevention initiatives)

The OIG conducted an unannounced inspection of the Iowa City VA Health Care System during the weeks of July 18 and July 25, 2022. 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. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

## Inspection Results

The OIG noted opportunities for improvement and issued six recommendations to the System Director and Chief of Staff in the following areas of review: Leadership and Organizational Risks; Quality, Safety, and Value; Medical Staff Privileging; and Environment of Care. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 24.

## Conclusion

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.

## 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

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## Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Iowa City VA 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.<sup>1</sup>

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.<sup>2</sup> Effective leadership has been cited as “among the most critical components that lead an organization to effective and successful outcomes.”<sup>3</sup>

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

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

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<sup>1</sup> VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

<sup>2</sup> 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), <https://doi.org/10.1136/bmjopen-2014-005055>.

<sup>3</sup> 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>.

<sup>4</sup> CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

## Methodology

The Iowa City VA Health Care System includes the Iowa City VA Medical Center and associated outpatient clinics in Illinois and Iowa. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from August 6, 2018, through July 27, 2022, the last day of the unannounced multiday evaluation.<sup>5</sup> During the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.<sup>6</sup> 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 System 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.

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<sup>5</sup> The OIG's last comprehensive healthcare inspection of the Iowa City VA Health Care System occurred in August 2018. The Joint Commission performed hospital, behavioral health, and home care accreditation reviews in August 2019.

<sup>6</sup> 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.<sup>7</sup> High-impact leaders should be person-centered and transparent, engage front-line staff members, have a “relentless focus” on their vision and strategy, and “practice systems thinking and collaboration across boundaries.”<sup>8</sup> 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.<sup>9</sup>

To assess this healthcare system’s leadership and risks, the OIG considered several 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 System Director (Director), Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director for Operations. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together less than one month, although the Director had served in the role since 2015, and several other team members had been in their positions for more than one year. To help assess the executive leaders’ engagement, the OIG interviewed the Director, permanent and acting Chiefs of Staff, ADPCS, and Associate

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

<sup>8</sup> Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

<sup>9</sup> Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care*, Institute for Healthcare Improvement White Paper, 2017.

Director for Operations regarding their knowledge, involvement, and support of actions to improve or sustain performance.<sup>10</sup>

## **Budget and Operations**

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of \$516,047,049 had increased over 16 percent compared to the previous year's budget of \$442,328,699.<sup>11</sup> The Director said leaders used the money to hire employees to support COVID-19 pandemic operations, pay overtime to those working in the vaccine clinic, and purchase special equipment. The Associate Director for Operations reported the budget increase supported COVID-19 expenses, which included significant costs for personal protective equipment and construction required to improve patient care rooms. In addition, the Associate Director for Operations stated that leaders established a community-based outpatient clinic in Burlington, Iowa about two years previously; however, the clinic had since outgrown its capacity. The Associate Director for Operations added that leaders planned to replace it with a larger outpatient clinic.

## **Employee Satisfaction**

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."<sup>12</sup> 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 healthcare system leaders.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.<sup>13</sup>

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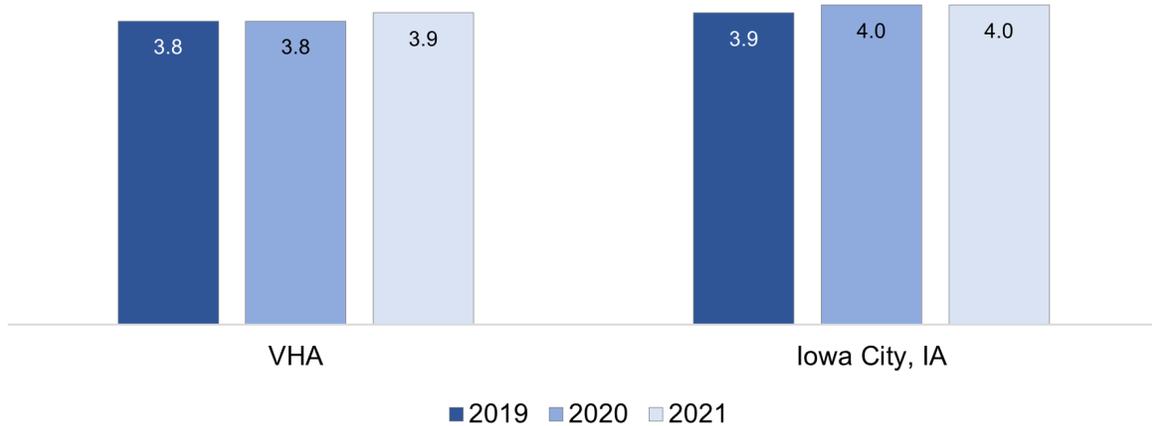
<sup>10</sup> The Director had assigned the Chief of Staff to assist the Radiology Department with administrative duties, and the Deputy Chief of Staff to serve as the acting Chief of Staff during recruitment and hiring of a chief radiologist. The acting Chief of Staff had been in the position for less than one month at the time of the OIG inspection; therefore, the permanently assigned and acting Chiefs of Staff were interviewed together.

<sup>11</sup> Veterans Health Administration (VHA) Support Service Center.

<sup>12</sup> "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

<sup>13</sup> The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders' All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

## Ability to Disclose a Suspected Violation



**Figure 2.** All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.

Source: VA All Employee Survey (accessed June 15, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

## Patient Experience

Veterans Health Administration (VHA) uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and benchmark performance against the private sector. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.<sup>14</sup>

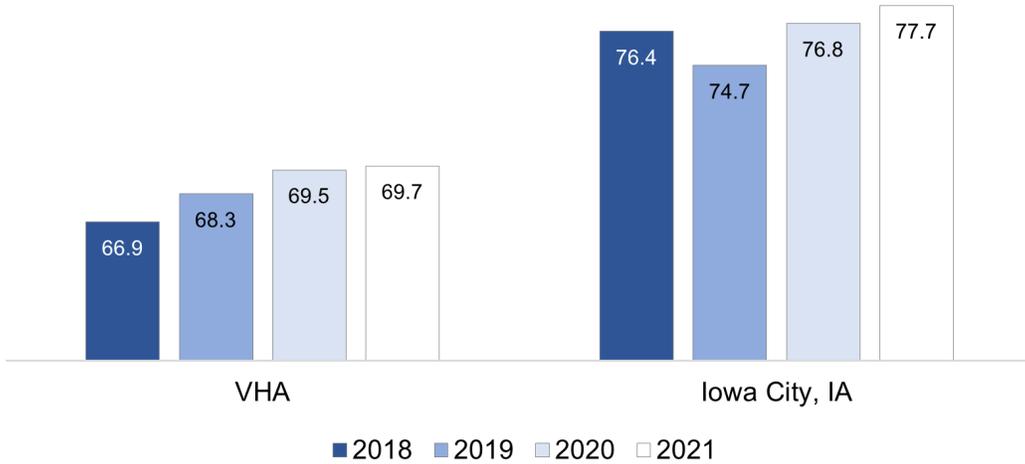
VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.<sup>15</sup> The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the healthcare system over time.<sup>16</sup>

<sup>14</sup> “Patient Experiences Survey Results,” VHA Support Service Center.

<sup>15</sup> “Patient Experiences Survey Results,” VHA Support Service Center.

<sup>16</sup> Scores are based on responses by patients who received care at this healthcare system.

### Inpatient Recommendation

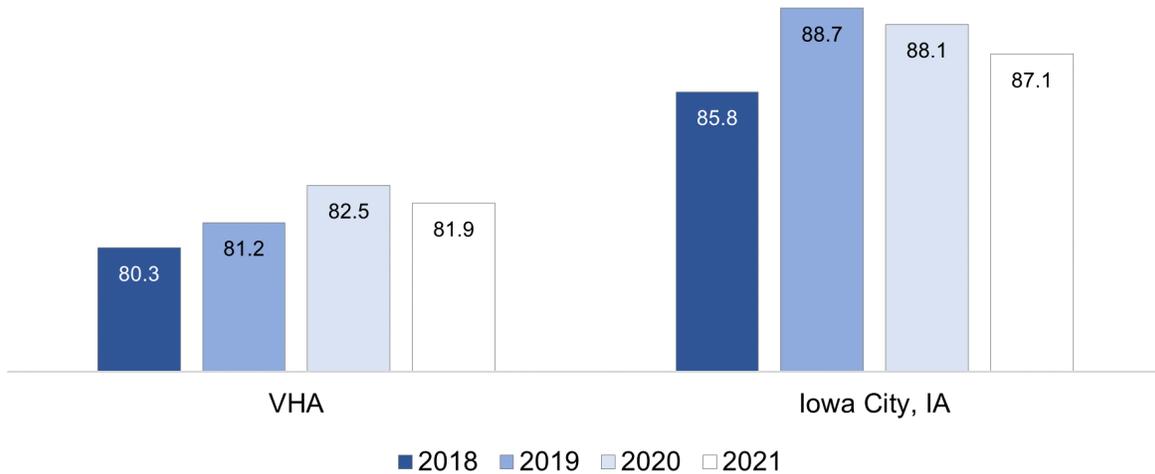


**Figure 3.** Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed May 23, 2022).

Note: The score is the percent of “Definitely yes” responses.

## Outpatient Patient-Centered Medical Home Satisfaction

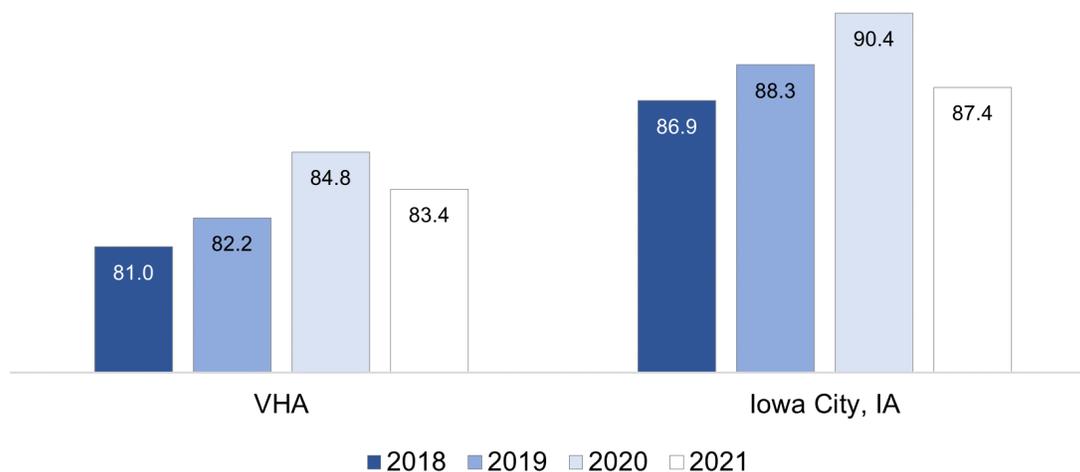


**Figure 4.** Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed May 23, 2022).

Note: The score is the percent of “Very satisfied” and “Satisfied” responses.

## Outpatient Specialty Care Satisfaction



**Figure 5.** Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed May 23, 2022).

Note: The score 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.<sup>17</sup> “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).”<sup>18</sup> 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

<sup>17</sup> Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

<sup>18</sup> 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.

recourse.”<sup>19</sup> 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.”<sup>20</sup> To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission’s standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.<sup>21</sup> 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 as well as lose trust from patients and staff.<sup>22</sup>

The Director reported being notified of sentinel events through direct calls and said quality management staff provided all executive leaders a daily briefing on the number of adverse events that required action and the actions that had been implemented. Furthermore, the Director explained that staff conducted root cause analyses, reviewed lessons learned, and monitored the implemented actions to ensure sustained improvements.<sup>23</sup> The Chief of Staff stated the healthcare system was on a journey to become a high-reliability organization and it had a positive culture where employees felt free to admit mistakes.<sup>24</sup> The ADPCS said leaders determined whether adverse events were sentinel events based on the degree of patient harm, but the Director made the final decision.

The Director reported having oversight responsibility to ensure leaders conducted institutional disclosures, if warranted. The Director described the disclosure process, which included seeking guidance from the Chief of Staff and patient safety staff and gathering as much information as possible about the event, including its effect on the patient. The Chief of Staff explained that

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<sup>19</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

<sup>20</sup> VHA Directive 1004.08.

<sup>21</sup> The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

<sup>22</sup> Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

<sup>23</sup> A root cause analysis is a focused review to identify the actual system- and process-related contributing factors of the event. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

<sup>24</sup> A high-reliability organization “is an organization with a goal of achieving ‘zero harm’ in an environment where accidents are expected due to complexity or risk factors.” VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

after receiving notification of the adverse event, leaders complete a clinical disclosure, then decide whether to conduct an institutional disclosure.<sup>25</sup>

## **Leadership and Organizational Risks Findings and Recommendations**

VHA requires leaders to conduct institution disclosures for adverse events that “resulted in or is reasonably expected to result in death or serious injury...including, for example sentinel events as defined by The Joint Commission.”<sup>26</sup> The OIG requested sentinel events and institutional and large-scale disclosures and reviewed the information staff reported. The OIG found that leaders did not consistently conduct institutional disclosures for sentinel events that may have contributed to patients’ deaths. Failure to perform an institutional disclosure can reduce patients’ trust in the organization. The Chief, Quality and Performance Improvement reported that leaders did not conduct institutional disclosures for most sentinel events because they believed they had authority to determine which events warranted it.

### **Recommendation 1**

1. The System Director determines any additional reasons for noncompliance and ensures the Chief of Staff conducts institutional disclosures for applicable sentinel events.

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<sup>25</sup> A clinical disclosure is a process where the “patient’s clinician informs the patient or the patient’s personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient’s care.” VHA Directive 1004.08.

<sup>26</sup> VHA Directive 1004.08.

Healthcare system concurred.

Target date for completion: June 1, 2024

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. The Risk Manager will ensure an institutional disclosure is conducted for all applicable sentinel events. The Patient Safety Manager will notify executive leaders and the Risk Manager when a sentinel event occurs. In Sept 2023, the Patient Safety Manager updated the monthly Patient Safety Report to include sentinel events and follow-up activities associated with the events including institutional disclosures for enhanced communication related to sentinel event activities. The Patient Safety Manager will report monthly sentinel events and follow-up activities associated with the events including if the event had an institutional disclosure to the Quality, Safety and Value Council chaired by the Director. The numerator is the number of applicable sentinel events that had an institutional disclosure conducted. The denominator is the total number of applicable sentinel events each month. The Patient Safety Manager will monitor compliance until 90 percent has been achieved and maintained for six consecutive months.

## Quality, Safety, and Value

VHA strives to provide healthcare services that compare “favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience.”<sup>27</sup> To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.<sup>28</sup> Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).<sup>29</sup>

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system’s committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system’s processes for conducting peer reviews of clinical care.<sup>30</sup> 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.”<sup>31</sup> Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.<sup>32</sup>

Finally, the OIG assessed the healthcare system’s culture of safety.<sup>33</sup> VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

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<sup>27</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

<sup>28</sup> VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (VHA rescinded this directive and replaced it with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

<sup>29</sup> VHA Directive 1100.16.

<sup>30</sup> 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.

<sup>31</sup> VHA Directive 1190.

<sup>32</sup> VHA Directive 1190.

<sup>33</sup> 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, accessed October 3, 2022, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf>.

## Quality, Safety, and Value Findings and Recommendations

VHA requires staff to investigate adverse events within seven days and document appropriately in the Joint Patient Safety Reporting system, or the patient safety manager must monitor the investigations until they are completed.<sup>34</sup> The OIG noted two of the sentinel event investigation dates were beyond the seven days, and the Patient Safety Manager did not monitor the investigations until they were completed. When the investigator does not complete the investigation within the required time frame, there may be a delay in staff identifying opportunities to improve quality of care and patient safety processes. The Chief, Quality and Performance Improvement attributed the noncompliance to staffing shortages in the Patient Safety Program, which left only the manager and one patient safety staff member to perform all required program duties.

### Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff complete adverse event investigations within seven days and document appropriately in the Joint Patient Safety Reporting system, or the Patient Safety Manager monitors the investigations until they are completed.

Healthcare system concurred.

Target date for completion: June 1, 2024

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. The Patient Safety Manager will include a section in the monthly Patient Safety Report related to the number of sentinel events and investigations completed within seven days or documentation that the Patient Safety Manager monitored the event until the investigation was completed from the month prior. The Patient Safety Manager will report monthly to the Quality, Safety and Value Council chaired by the Director, the number of sentinel events and investigations completed within seven days or documentation that the Patient Safety Manager monitored the event. The numerator is the total number of sentinel events that had an investigation completed within seven days or documentation that the Patient Safety Manager monitored the event until the investigation was completed. The denominator is the total number of sentinel events identified each month. The Patient Safety Manager will monitor until 90 percent compliance is achieved and maintained for six consecutive months.

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<sup>34</sup> The Joint Patient Safety Reporting system is a database staff at VA facilities use to report patient safety events. VHA National Center for Patient Safety, *JPSR Business Rules and Guidebook*, July 2020. (VHA updated this guidebook to VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.)

## 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.”<sup>35</sup> 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.”<sup>36</sup>

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.<sup>37</sup> LIPs are granted clinical privileges for a limited time and must be repriviledged prior to their expiration.<sup>38</sup>

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs’ professional performance. The Focused Professional Practice Evaluation process occurs when a practitioner 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.<sup>39</sup>

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.<sup>40</sup> 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 and aligned under the chief of staff. VHA also requires facilities to have credentialing

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<sup>35</sup> 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.)

<sup>36</sup> VHA Handbook 1100.19.

<sup>37</sup> VHA Handbook 1100.19.

<sup>38</sup> VHA Handbook 1100.19.

<sup>39</sup> VHA Handbook 1100.19.

<sup>40</sup> VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.<sup>41</sup>

The OIG interviewed key managers and selected and reviewed the privileging folders of 30 medical staff members who had a Focused or Ongoing Professional Practice Evaluation.

### **Medical Staff Privileging Findings and Recommendations**

VHA requires service chiefs to incorporate service-specific criteria in Ongoing Professional Practice Evaluations.<sup>42</sup> The OIG found some Ongoing Professional Practice Evaluations lacked service-specific criteria. This may have resulted in insufficient data to support leaders' decisions to continue the LIPs' clinical privileges. The acting Chief of Staff reported that a few specialty service chiefs did not update the form to include the required criteria.

### **Recommendation 3**

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs incorporate service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.

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<sup>41</sup> 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.

<sup>42</sup> VHA Handbook 1100.19; VHA Directive 1100.21(1). For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

Healthcare system concurred.

Target date for completion: July 1, 2024

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The national Ongoing Professional Practice Evaluation templates for all medical specialties were implemented at the healthcare system in October 2022, which includes service-specific criteria. Each year the credentialing and privileging staff review all Ongoing Professional Practice Evaluation templates to ensure current national guidelines are implemented and include service-specific criteria. The Professional Staff Evaluation and Credentialing Committee annually approve these Ongoing Professional Practice Evaluation templates. The Credentialing and Privileging Manager will track and monitor all completed Ongoing Professional Practice Evaluations monthly for inclusion of service-specific criteria. The numerator is the number of completed Ongoing Professional Practice Evaluations that include service-specific criteria. The denominator is the total number of completed Ongoing Professional Practice Evaluations for each month. The Credentialing and Privileging Manager will report the monthly compliance results to the Medical Executive Board chaired by the Chief of Staff until 90 percent compliance is achieved and sustained for six consecutive months.

VHA required practitioners with similar training and privileges to evaluate LIPs.<sup>43</sup> The OIG found that another similarly trained and privileged practitioner did not complete one solo LIP's Ongoing Professional Practice Evaluation.<sup>44</sup> As a result, the LIP continued to deliver care without a thorough evaluation, which could have negatively affected quality of care and patient safety. The acting Chief of Staff reported that although the reviewer (a psychologist) and the reviewed LIP (a medical doctor) both worked in the same service, the service chief did not consider that the two practitioners had different degrees.

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<sup>43</sup> VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators." VHA now requires another practitioner with equivalent specialized training and similar privileges to complete the professional practice evaluation. VHA Directive 1100.21(1).

<sup>44</sup> VHA refers to a solo practitioner as being one provider in the facility who is privileged in a particular specialty. VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners," August 29, 2016. (This memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on December 18, 2020. The December 18, 2020, memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on May 18, 2021.)

## Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures practitioners with equivalent specialized training and similar privileges complete the Ongoing Professional Practice Evaluations of licensed independent practitioners.

Healthcare system concurred.

Target date for completion: July 1, 2024

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The healthcare system service chiefs will coordinate with the Ongoing Professional Practice Evaluation reviewer to ensure the reviewer and reviewed providers have similar training and privileges. The credentialing and privileging staff will track and monitor Ongoing Professional Practice Evaluations monthly. The numerator is the number of completed Ongoing Professional Practice Evaluations reviewed by providers with similar training and privileges. The denominator is the total number of completed Ongoing Professional Practice Evaluations for each month. The Credentialing and Privileging Manager will report the monthly compliance results to the Medical Executive Board chaired by the Chief of Staff until 90 percent compliance is achieved and sustained for six consecutive months.

## 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 the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.<sup>45</sup> The physical environment of a healthcare organization must not only be functional but should also promote healing.

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 assessed compliance in selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.<sup>46</sup>

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.<sup>47</sup> VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times in emergencies and contribute to a safe healthcare environment.<sup>48</sup>

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 10 patient care areas:

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<sup>45</sup> VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded and replaced this directive with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. VHA mended this directive September 7, 2023.)

<sup>46</sup> Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023.)

<sup>47</sup> Centers for Disease Control and Prevention – National Center for Health Statistics, “Drug Overdose Deaths in the U.S. Top 100,000 Annually,” November 17, 2021, accessed March 22, 2022, [https://www.cdc.gov/nchs/pressroom/nchs\\_press\\_releases/2021/20211117.htm](https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm).

<sup>48</sup> Opioids are medications that are “effective at reducing pain” but “when taken in excess, can lead to respiratory arrest.” Naloxone “is a highly effective treatment for reversing an opioid overdose.” “Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit,” VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, “Automated External Defibrillators (AEDs),” accessed December 16, 2021, <https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds>. “Pharmacy Benefits Management Services,” Department of Veterans Affairs, accessed October 6, 2021, [https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid\\_Overdose\\_Education\\_and\\_Naloxone\\_Distribution.asp](https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp).

- Iowa City VA Medical Center
  - Emergency Department
  - Intensive care unit
  - Medical/surgical inpatient units (5 East and 7 East)
  - Mental Health Inpatient Unit
  - Neurology clinic
  - Women’s health clinic
- Federal Building Campus
  - Dental clinic
  - Occupational and physical therapy clinic
  - Prosthetics clinic

## Environment of Care Findings and Recommendations

The Joint Commission requires healthcare staff to ensure “areas used by patients are clean” and “interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.”<sup>49</sup> The OIG found that some areas inspected had dirty or stained floors, while other areas had dirty grills or calcium buildup on the ice machines’ waterspouts, which presented a potential risk of infection to both patients and staff.<sup>50</sup> The Hospital Housekeeping Officer and the Operation and Maintenance Supervisor reported that although housekeeping staff cleaned the outside of the ice machine as needed, they did not send notification of calcium buildup to the Engineering Service. The Operation and Maintenance Supervisor further stated that Engineering Service staff cleaned the ice machines once a quarter and cited a lack of attention to detail as a factor contributing to the noncompliance.

Additionally, the Hospital Housekeeping Officer said the alcohol-based hand sanitizer dispensers drip and stain the vinyl floors. The officer further reported a lack of oversight and attention to detail by the Housekeeping Supervisor and assigned housekeeper, respectively, as issues contributing to noncompliance. The Hospital Housekeeping Officer added that a piece of equipment had been removed from one of the areas, leaving the exposed floor dirty and stained.

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<sup>49</sup> The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, January 1, 2022.

<sup>50</sup> The medical center’s medical/surgical inpatient units had dirty or stained floors. The Emergency Department, intensive care unit, mental health inpatient unit, and the occupational and physical therapy clinic had ice machines with dirty grills or calcium buildup.

## Recommendation 5

5. The System Director evaluates and determines any additional reasons for noncompliance and ensures managers keep areas used by patients clean, safe, and suitable for the care, treatment, and services provided.

Healthcare system concurred.

Target date for completion: June 1, 2024

Healthcare system response: The System Director evaluated and determined no additional reasons for noncompliance. The Healthcare System has the following action plans in place:

Ice machines: In September 2023 the Engineering Maintenance and Operations staff implemented an ice machine preventive maintenance checklist that requires cleaning of the waterspout and nozzle. The numerator is the number of ice machines that have documented evidence that the preventive maintenance was completed each month. The denominator is the number of ice machines requiring preventive maintenance each month. The Engineering Maintenance and Operations Engineer will be responsible for monitoring compliance until 90 percent or higher is achieved and sustained for six consecutive months, and report monthly to the Quality, Safety and Value Council chaired by the Director.

Hand sanitizer dispenser: In September 2023 the environment management service staff added hand sanitizer dispensers to the inspection form. The Environmental Management Service Supervisor will conduct weekly sanitizer dispenser inspections on inpatient care units. The numerator is the number of hand sanitizer dispensers that had an inspection completed. The denominator is the total number of hand sanitizer dispensers on inpatient units inspected each month. The Housekeeping Aid Supervisor will monitor until 90 percent or higher compliance is achieved and sustained for six consecutive months and report monthly to the Quality, Safety and Value Council chaired by the Director.

Flooring: The facility staff in clinical and nonclinical areas are responsible for entering work orders into an electronic tracking system for stained or damaged flooring or when equipment is moved. The environment management service staff will inspect the floor for cleaning or replacement and submit a request to engineering staff for floors that require replacement. The numerator is the number of work orders related to damaged floors completed in a month. The denominator is the number of work orders related to damaged floors created in a month. The Engineering Maintenance and Operations Engineer will monitor until 90 percent or higher compliance is achieved and sustained for six consecutive months and report monthly to the Quality, Safety and Value Council chaired by the Director.

At facilities with mental health inpatient units, VHA requires staff to perform systematic environmental assessments using the Mental Health Environment of Care Checklist to identify

and address environmental risks for patients under treatment.<sup>51</sup> The Mental Health Environment of Care Checklist criteria state “panic alarms are periodically tested to ensure that they are functioning correctly” and “testing should be recorded in a log and include response-time by police.”<sup>52</sup> The OIG reviewed the system’s log for panic alarm testing that occurred from April 1, 2022, through June 30, 2022, and did not find evidence staff monitored VA police response times. Failure to monitor police response times may put patients, visitors, and staff at risk in the event of an actual emergency. The Supervisory Police Officer, Operations reported that VA police tested panic alarms for functionality. The Chief of Police said that staff did not monitor police response times because it would require mimicking a real event, which could result in patient agitation and disruption of patient care.

## Recommendation 6

6. The System Director determines any additional reasons for noncompliance and ensures staff monitor and document VA police response times to panic alarm testing in the Mental Health Inpatient Unit on a regular basis.

Healthcare system concurred.

Target date for completion: June 1, 2024

Healthcare system response: The System Director reviewed the recommendation and did not identify any additional reasons for noncompliance. On September 11, 2023, the Police Department modified the spreadsheet for the panic alarm function testing to include police response times in the Mental Health Inpatient Unit. Beginning in fiscal year 2024, the Police Operations Lieutenant or designee will complete the Mental Health Inpatient Unit panic alarm function testing and document police response times on a spreadsheet. The Chief of Police or designee will report monthly compliance data at the Quality, Safety and Value Council chaired by the Director. The numerator is the number of panic alarm tests completed with documented police response time. The denominator is the number of panic alarm testing completed each month in the Mental Health Inpatient Unit. The Chief of Police will monitor until 90 percent compliance is achieved and sustained for six consecutive months.

<sup>51</sup> VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

<sup>52</sup> VHA National Center for Patient Safety, “Mental Health Environment of Care Checklist,” September 30, 2020.

## **Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives**

Suicide prevention remains the top clinical priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent “13.7 [percent] of suicides among U.S. adults.”<sup>53</sup> Additionally, “among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019.”<sup>54</sup>

VHA implemented various evidence-based approaches to reduce veteran suicides, including 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.<sup>55</sup> The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from emergency departments or urgent care centers and receive “structured post-discharge follow-up to facilitate engagement in outpatient mental health care.”<sup>56</sup> The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients’ discharge from emergency departments or urgent care centers and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 50 randomly selected patients who were seen in the Emergency Department or urgent care center from December 31, 2020, through August 1, 2021.

### **Mental Health Findings and Recommendations**

The OIG made no recommendations.

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<sup>53</sup> Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

<sup>54</sup> Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*.

<sup>55</sup> 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.)

<sup>56</sup> Deputy Under Secretary for Health for Operations and Management memo, “Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives,” October 17, 2019. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions,” October 1, 2021.)

## Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided six recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of 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 patient and staff safety issues or adverse events. The recommendations are attributable to the System Director and Chief of Staff. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

**Table A.1. Summary Table of Recommendations**

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> <li>The Chief of Staff conducts institutional disclosures for applicable sentinel events.</li> </ul>
Quality, Safety, and Value	<ul style="list-style-type: none"> <li>Staff complete adverse event investigations within seven days and document appropriately in the Joint Patient Safety Reporting system, or the Patient Safety Manager monitors the investigations until they are completed.</li> </ul>
Medical Staff Privileging	<ul style="list-style-type: none"> <li>Service chiefs incorporate service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.</li> <li>Practitioners with equivalent specialized training and similar privileges complete the Ongoing Professional Practice Evaluations of licensed independent practitioners.</li> </ul>
Environment of Care	<ul style="list-style-type: none"> <li>Managers keep areas used by patients clean, safe, and suitable for the care, treatment, and services provided.</li> <li>Staff monitor and document VA police response times to panic alarm testing in the Mental Health Inpatient Unit on a regular basis.</li> </ul>
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	<ul style="list-style-type: none"> <li>None</li> </ul>

## Appendix B: Healthcare System Profile

The table below provides general background information for this mid-high complexity (1c) affiliated healthcare system reporting to VISN 23.<sup>1</sup>

**Table B.1. Profile for Iowa City VA Health Care System (636A8)  
(October 1, 2018, through September 30, 2021)**

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Total medical care budget	\$370,937,101	\$442,328,699	\$516,047,049
Number of:			
• Unique patients	51,064	49,509	52,708
• Outpatient visits	585,985	533,502	607,865
• Unique employees§	1,706	1,745	1,798
Type and number of operating beds:			
• Medicine	33	33	33
• Mental health	15	15	15
• Surgery	19	19	19
Average daily census:			
• Medicine	33	31	32
• Mental health	12	12	11
• Surgery	9	6	8

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, 2018, through September 30, 2019.

†October 1, 2019, through September 30, 2020.

‡October 1, 2020, through September 30, 2021.

§Unique employees involved in direct medical care (cost center 8200).

<sup>1</sup> VHA medical facilities are classified according to a complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized 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.

## Appendix C: VISN Director Comments

### Department of Veterans Affairs Memorandum

Date: September 27, 2023

From: Director, VA Midwest Health Care Network (10N23)

Subj: Comprehensive Healthcare Inspection of the Iowa City VA Health Care System in Iowa (ICVAHCS)

To: Director, Office of Healthcare Inspections (54HF05)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection draft report of the Iowa City VA Health Care System. I concur with the six recommendations in this report.
2. ICVAHCS has submitted the action plans and monitors to demonstrate compliance with the recommendations.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts.

*(Original signed by:)*

Robert P. McDivitt, FACHE

Executive Director, VA Midwest Health Care Network (VISN 23)

## Appendix D: Healthcare System Director Comments

### Department of Veterans Affairs Memorandum

Date: September 25, 2023

From: Director, Iowa City VA Health Care System (636A8)

Subj: Comprehensive Healthcare Inspection of the Iowa City VA Health Care System in Iowa

To: Director, VA Midwest Health Care Network (10N23)

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection draft report of the Iowa City VA Health Care System. I concur with the six recommendations in this report.
2. I have submitted the action plans and monitors to demonstrate compliance with the recommendations.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts.

*(Original signed by:)*

Heath J Streck  
Acting Director

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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<b>Inspection Team</b>	Rachel Agbi, DBA, MSN Patricia Calvin, MBA, RN Laura Harrington, MSN, RN Rowena Jumamoy, MSN, RN Judy Montano, MS
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<b>Other Contributors</b>	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Jarvis Yu, MS
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Director, VISN 23: VA Midwest Health Care Network  
Director, Iowa City VA Health Care System (636A8)

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