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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System in Minnesota

CHIP Report | 22-02666-214 | September 19, 2023

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Figure 1. *St. Cloud VA Medical Center of the St. Cloud VA Health Care System in Minnesota.*

Source: https://www.va.gov/st-cloud-health-care/locations/ (*accessed February 28, 2023*).

Abbreviations

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 St. Cloud VA Health Care System, which includes the St. Cloud VA Medical Center and multiple outpatient clinics in Minnesota.[1] 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 St. Cloud VA Health Care System from June 27 through July 19, 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 two recommendations to the Director in the Leadership and Organizational Risks and Mental Health areas of review. These results are

[1] This healthcare system only had a mental health unit for inpatient care.

detailed throughout the report, and the recommendations are summarized in appendix A on page 18.

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 Healthcare System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 20 and 21, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendation 2 closed. The OIG will follow up on the planned actions for the open recommendation until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the St. Cloud VA Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes.[1] The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[2]

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.[3] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[4]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[5]

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)

[1] This healthcare system only had a mental health unit for inpatient care.

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

[3] 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.

[4] 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.

[5] 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 St. Cloud VA Health Care System includes the St. Cloud VA Medical Center and associated outpatient clinics in Minnesota. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from July 20, 2019, through July 19, 2022, the last day of the unannounced multiday evaluation.[6] 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.[7] 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.

[6] The OIG's last comprehensive healthcare inspection of the St. Cloud VA Health Care System occurred in July 2019. The Joint Commission performed hospital, behavioral health, and home care accreditation reviews in September 2019.

[7] 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.[8] 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."[9] 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.[10]

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 Director, Chief of Staff, Associate Director for Patient Care Services/Nurse Executive, and Associate Director. The Chief of Staff and Associate Director for Patient Care Services/Nurse Executive oversaw patient care, which included managing service directors and program chiefs. At the time of the OIG inspection, the executive team had worked together for over two years, although the Associate Director had served in the role since 2012.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $481,143,333 had increased by approximately 17 percent compared to the previous year's budget

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

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

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

of $411,683,448.[11] The Associate Director stated the system was well-funded and that allowed leaders to increase salaries, offer incentives, and use multiple employee recruitment and retention strategies. The Associate Director added that leaders conducted regular "Hire Right, Hire Fast" events so potential applicants could begin work before they completed requirements such as physical exams.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] 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 to 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[13]

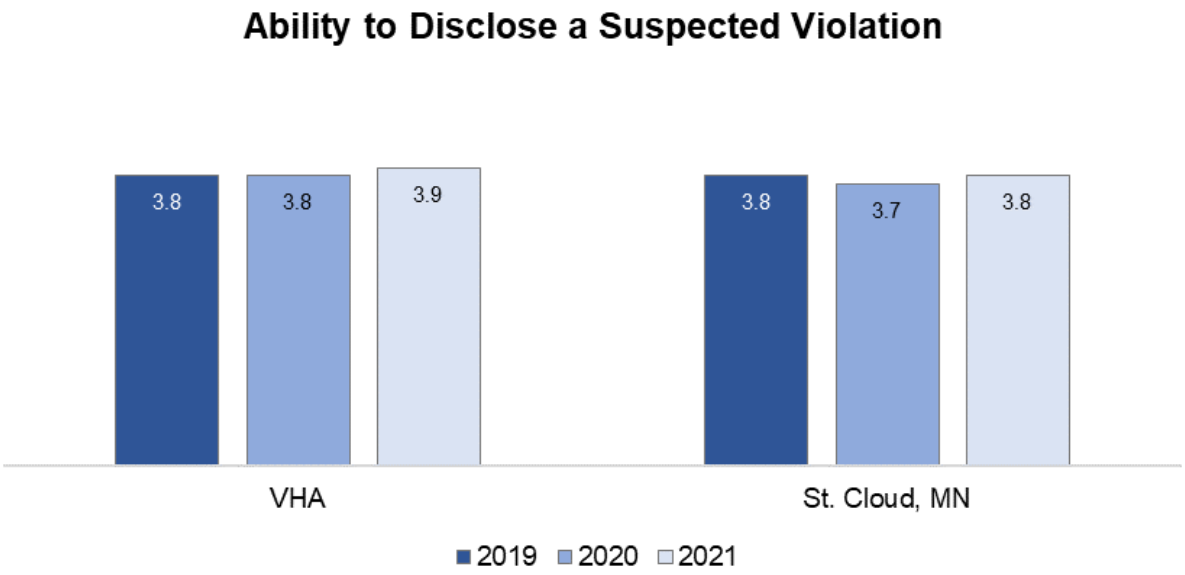

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed May 24, 2022).

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

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

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

[13] 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).

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.[14]

VHA also collects Survey of Healthcare Experiences of Patients data from Patient-Centered Medical Home (primary care) and Specialty Care surveys.[15] The OIG reviewed responses to two relevant survey questions that reflect patient experiences with the healthcare system from FYs 2018 through 2021. Figures 3 and 4 provide survey results for VHA and the healthcare system over time.[16]

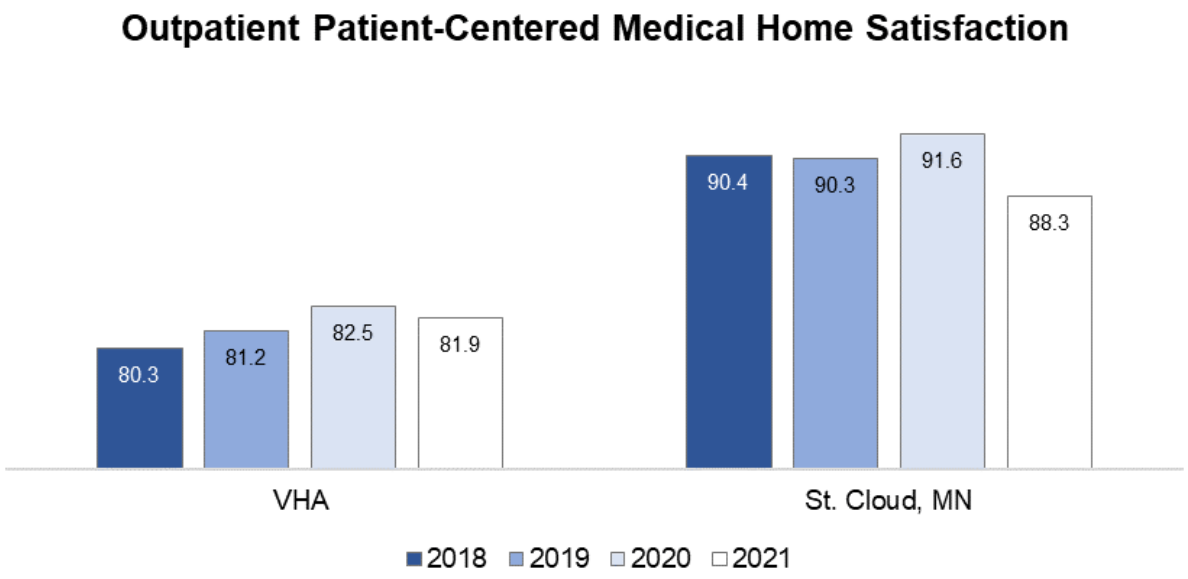

Figure 3. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

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

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

[16] Scores are based on responses by patients who received care at this healthcare system.

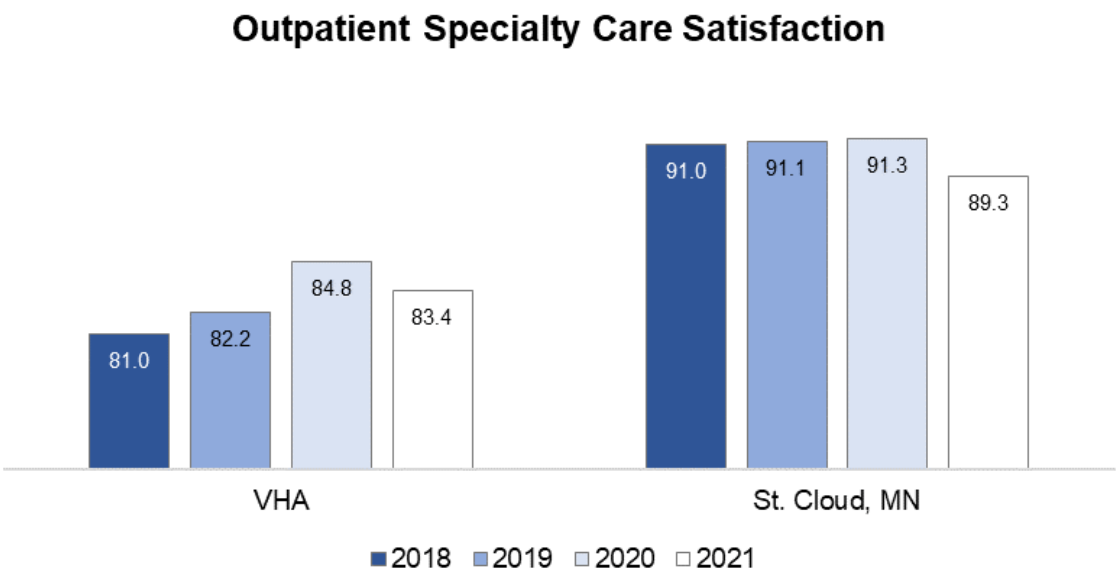

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.[17] "A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[18] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and

[17] 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/.

[18] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

recourse."[19] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[20] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

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.[21] 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.[22]

The OIG requested sentinel events and institutional and large-scale disclosures that occurred from July 20, 2019, through June 26, 2022, and reviewed the information staff reported. According to the Director, the healthcare system is a leader in logging adverse patient events into the VHA adverse event reporting system. The Director reported learning about adverse events directly, during executive leadership team meetings, or from front-line staff in morning huddles.

When the OIG asked about the process for determining whether an institutional disclosure was needed, the Director discussed deferring to the Chief of Staff, VISN, and the Office of General Counsel. The Chief of Staff explained that leaders reviewed the adverse event, and if they determined the care was medically acceptable, they did not conduct an institutional disclosure. If a patient had a fall without any change in medical status, the Chief of Staff said leaders would not provide an institutional disclosure to the patient or next of kin. However, the Chief of Staff reported conducting disclosures if a reported fall resulted in a change of condition, a fracture, or different lifestyle requirements.

The Quality Safety and Value Director said that leaders went through the hiring process three times before selecting the new Patient Safety Manager, who was due to start on July 14, 2022. The Risk Manager discussed learning of adverse events through staff, service chiefs, and colleagues in the Quality Safety and Value Service and being in close contact with the prior Patient Safety Manager to review adverse events to decide if they met the sentinel event definition.

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

[20] VHA Directive 1004.08.

[21] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

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

Leadership and Organizational Risks Findings and Recommendations

VHA considers the disclosure of harmful events "consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence" and requires leaders to inform or disclose to a patient or patient's personal representative when an adverse event causes or may cause a patient's death or serious injury.[23] The OIG found that leaders did not conduct an institutional disclosure for some of the sentinel events that resulted in patients' deaths. Failure to provide institutional disclosures may reduce patients' trust in the VA. The Chief of Staff reported that leaders did not conduct the institutional disclosures due to staffing changes, the COVID-19 pandemic, or misinterpretation of the guidance.

Recommendation 1

1. The Director evaluates and determines any additional reasons for noncompliance and ensures leaders conduct institutional disclosures for applicable sentinel events.

Healthcare system concurred.

Target date for completion: April 30, 2024

Healthcare system response: The Director evaluated and determined there were no additional reasons for noncompliance. The Risk Manager, in consultation with Quality Safety and Value staff and executive leadership, has evaluated the current process for reviewing sentinel events. The Risk Manager and Patient Safety Manager will discuss sentinel events weekly to determine if an institutional disclosure is needed. The Risk Manager and Patient Safety Manager will use a spreadsheet to track sentinel events and institutional disclosures including determination if an institutional disclosure was warranted and date the disclosure was conducted. The Risk Manager will report monthly to the Quality Safety Value Council the number of sentinel events from the previous month, the number of those sentinel events determined to need an institutional disclosure (denominator) and the number of institutional disclosures conducted (numerator). Reporting will be ongoing until compliance of 90 percent is sustained for six consecutive months.

[23] VHA Directive 1004.08.

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."[24] 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.[25] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[26]

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.[27] 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."[28] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[29]

Finally, the OIG assessed the healthcare system's culture of safety.[30] 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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[24] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[25] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (VHA rescinded and replaced this directive with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

[26] VHA Directive 1100.16.

[27] 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.

[28] VHA Directive 1190.

[29] VHA Directive 1190.

[30] 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 13, 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

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[31] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[32]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[33] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[34]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when 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.[35]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[36] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the chief of staff. VHA also requires facilities to have credentialing

[31] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Directive 1100.20.

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

The OIG interviewed key managers and selected and reviewed the privileging folders of 28 medical staff members who had a Focused or Ongoing Professional Practice Evaluation.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[37] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

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.[38] 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.[39]

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.[40] 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.[41]

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:

- Community living center (buildings 49-2 and 50-2)

[38] 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.)

[39] 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.

[40] 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.

[41] 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.

- Mental health inpatient unit
- Primary care clinic (Team 4)
- Urgent care center
- Women's health clinic (Team 5)

Environment of Care Findings and Recommendations

The OIG made no recommendations.

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."[42] 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."[43]

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.[44] 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."[45] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from the urgent care center 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 30 randomly selected patients who were seen in the urgent care center from December 31, 2020, through August 1, 2021.

[42] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

[43] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*.

[44] 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.)

[45] 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.)

Mental Health Findings and Recommendations

VHA requires that veterans who have a positive suicide risk screen during an emergency department or urgent care center visit and are determined to be safe for discharge have a current suicide safety plan in place.[46] The OIG found that one of eight electronic health records (13 percent) reviewed for patients with a positive screen and discharged from the urgent care center lacked evidence of a suicide safety plan. Lack of safety plans may lead to missed opportunities for staff to provide patients with strategies and resources to help reduce their risk of suicide. The Suicide Prevention Coordinator reported that a specific provider lacked training and did not fully understand the requirement.

Recommendation 2

2. The Director evaluates and determines any additional reasons for noncompliance and ensures staff complete suicide safety plans for patients with a positive suicide risk screen who are determined safe for discharge home from the urgent care center.[47]

Healthcare system concurred.

Target date for completion: Completed.

Healthcare system response: The Director evaluated and determined there were no additional reasons for noncompliance. Prior to the OIG finding, staff identified gaps in completing suicide safety plans for patients with a positive suicide risk screen that were discharged home from the urgent care center. A workgroup convened in August 2021 to develop a new standard operating procedure that clearly identified each step in the process with delineated roles and responsibilities. A monthly summary audit of the Safety Planning for Emergency Department Initiatives Report has been completed showing a sustained 90 percent compliance for six consecutive months. The numerator is the number of patients discharged home from the urgent care center with a positive suicide risk screen with a documented suicide safety plan. The denominator is the number of patients discharged home from the urgent care center with a positive suicide risk screen. Compliance of 90 percent sustained for six consecutive months was achieved in January 2023.

[46] 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." 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."

[47] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

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 two 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 two OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Director. The intent is for leaders to use 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	• Leaders conduct institutional disclosures for applicable sentinel events.
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Staff complete suicide safety plans for patients with a positive suicide risk screen who are determined safe for discharge home from the urgent care center.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 23.[1]

Table B.1. Profile for St. Cloud VA Health Care System (656)
(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	$313,673,556	$411,683,448	$481,143,333
Number of:			
• Unique patients	39,020	37,544	38,132
• Outpatient visits	440,059	387,580	431,324
• Unique employees§	1,488	1,513	1,521
Type and number of operating beds:			
• Community living center	225	225	225
• Domiciliary	148	148	148
• Mental health	15	15	15
Average daily census:			
• Community living center	276	206	139
• Domiciliary	143	82	72
• Mental health	13	11	11

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).

[1] VHA medical facilities are classified according to a complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." "VHA Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). 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: August 29, 2023

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

Subj: Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System in Minnesota

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

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

1. This memo is in response to the Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System in Minnesota.
2. I concur with the findings, recommendations, and submitted action plans.

(Original signed by:)

Robert P. McDivitt, FACHE
Executive Director
VA Midwest Healthcare Network (VISN 23)

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: August 24, 2023

From: Director, St. Cloud VA Health Care System (656)

Subj: Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System in Minnesota

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 St. Cloud VA Health Care System in Minnesota. I concur with the two recommendations in this report.
2. I am submitting the plan and completed monitors to demonstrate compliance with one of the recommendations and an ongoing monitoring plan for the other recommendation.
3. I appreciate the OIG's partnership in our continuous improvement efforts.

(Original signed by:)

Brent A. Thelen, PhD

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