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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

CHIP Report | **22-03165-46** | **January 3, 2024**

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Figure 1. *Richard L. Roudebush VA Medical Center in Indianapolis, Indiana. Source: https://www.va.gov/indiana-health-care/locations/ (accessed November 6, 2023).*

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Richard L. Roudebush VA Medical Center, which includes multiple outpatient clinics in Indiana. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

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

The OIG initiated an unannounced inspection of the Richard L. Roudebush VA Medical Center during the week of February 6, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

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

delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 18.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 21–22, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

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

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

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

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

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

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

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

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

Methodology

The Richard L. Roudebush VA Medical Center includes multiple outpatient clinics in Indiana. General information about the medical center can be found in appendix B.

The inspection team conducted a review during the week of February 6, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until medical center leaders complete corrective actions. The Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the Richard L. Roudebush VA Medical Center occurred January 28 through February 1, 2019. The Joint Commission performed hospital, behavioral health care, home care, and laboratory accreditation reviews in April and June 2021.

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

Results and Recommendations

Leadership and Organizational Risks

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

To assess this medical center's leadership and risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive leaders had worked together for four months since the Director joined in September 2022. The Assistant Director, appointed in January 2012, was the most tenured leader.

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

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

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

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

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $802,364,379 had increased by almost 5 percent compared to the previous year's budget of $766,070,143.[10] The Director and ADPCS reported spending some of the funds on contracts for nurses in the operating room, Emergency Department, and medical/surgical units. The Director also stated the budget supported contracting environmental management service staff and replacing robotic dispensing equipment in the pharmacy. The Chief of Staff described using funds to recruit clinicians in hard-to-fill specialties like ophthalmology and orthopedic surgery.[11]

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 medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[13] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The OIG found that the medical center's averages were similar to VHA's, progressively increasing from FYs 2020 to 2022. Facility leaders attributed the scores to leaders walking around the medical center and frequently communicating with staff. The Chief of Staff added that leadership stabilization in key positions likely resulted in the improved scores. The ADPCS reported believing dressing in scrubs like the staff and visiting them in patient care units also helped build trust and increase the scores.

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

[11] Ophthalmologists treat eye conditions; and orthopedic surgeons treat bone, joint, ligament, tendon, and muscle disorders.

[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.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Richard L. Roudebush VA Medical Center	3.7	3.8	3.9

Source: VA All Employee Survey (accessed November 8, 2022).

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

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

The medical center's inpatient satisfaction survey results indicated patients were more satisfied with the care they received at this medical center compared to VHA patients nationally. The Chief of Staff, ADPCS, and Assistant Director stated that excessive noise negatively affected patient satisfaction. The ADPCS reported implementing several measures to reduce noise at night: eliminating environmental management staff's floor buffing, decreasing overhead paging, installing a Yacker Tracker to signal excessive noise, and having nurse leaders visit patient areas in the evening instead of at night.[15]

Patients' satisfaction with their primary care experiences improved in FY 2022, but satisfaction with specialty care declined slightly. The ADPCS said that improved communication and collaboration between social workers and primary care teams, as well as staff's use of scripted text to respond to patients, may have contributed to the improved satisfaction. The Chief of Staff highlighted having consistent providers and improved access to care in the ophthalmology, cardiology, and orthopedics clinics to increase patient satisfaction.

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

[15] Yacker Tracker is a tool used "to monitor the noise levels in various parts of" hospitals, such as waiting rooms and nurse's stations. "Yacker Tracker," AGI Attention Getters Inc., accessed June 22, 2023, https://yackertracker.com/uses/.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	73.7	69.7	71.5	68.9	74.1
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	82.5	85.9	81.9	82.0	81.7	83.9
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	82.9	83.3	85.0	83.1	84.7

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

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

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

Identified Factors Related to Possible Lapses in Care and Medical Center Leaders' Responses

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

[16] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[17] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[18]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[19] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[20] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[22]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. When asked about the patient safety processes at the facility, the Director, Chief of Staff, and ADPCS said that patient safety staff reported events to leaders daily. The Chief of Staff also stated staff incorporated events reported through the Joint Patient Safety Reporting system into high-reliability organization huddles and discussed them to identify trends.[23] Additionally, the ADPCS said educating staff on the reporting process had increased the number of events they entered in the system and resulted in a positive cultural change. The Deputy Chief, Quality, Safety, and Value

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

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

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

[21] VHA Directive 1004.08.

[22] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The new directive contains similar language regarding patient safety as the rescinded handbook.)

[23] The Joint Patient Safety Reporting system "standardizes event capture and data management on medical errors and close calls/near misses for the Military and Veterans Health Systems." "VHA National Center for Patient Safety," Department of Veterans Affairs, accessed March 27, 2022, https://www.patientsafety.va.gov/about/faqs.asp. "A high-reliability organization (HRO) 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.

added that leaders recognized staff with *Good Catch Awards* (a baseball signed by executive leaders).[24]

The Risk Manager reported relying on VHA guidance and consultation with the regional counsel for determining the type of disclosure to conduct. The Chief of Staff described coordinating with the Risk Manager to determine when events warranted institutional disclosures.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[24] "The 'Good Catch Award' recognizes employees who report close calls or other patient safety concerns." "VA Boston Displays Transparency in Patient Safety," VHA National Center for Patient Safety, accessed March 27, 2023, https://www.patientsafety.va.gov/PATIENTSAFETY/features/VA_Boston_Displays_Transparency_in_Patient_Safety.asp.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[25] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[27]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[28] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[29]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[30] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[31] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[32]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed 16 deaths that occurred within 24 hours of inpatient admission during FY 2022. There were no suicides that occurred within seven days of discharge from an inpatient mental health unit during the same time frame.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[27] VHA Directive 1100.16.

[28] VHA Handbook 1050.01; VHA Directive 1050.01.

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

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

[31] VHA Directive 1190.

[32] VHA Directive 1190.

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."[33] 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."[34]

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

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 (OPPE) to ensure the continuous delivery of quality care.[37]

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.[38] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires each facility to have credentialing and

[33] 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.)

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[39]

The OIG interviewed key managers and selected and reviewed the privileging folders for 26 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires providers with equivalent specialized training and similar privileges to evaluate LIPs on an ongoing basis.[40] The OIG found that providers with similar training and privileges did not consistently evaluate LIPs who were reprivileged. This could result in LIPs providing care without a thorough evaluation of their practices, which could jeopardize patient safety. The Chief of Staff attributed the noncompliance to lack of oversight at the service level.

Recommendation 1

1. The Chief of Staff ensures providers with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.

Medical center concurred.

Target date for completion: 1/31/2024

Medical center response: The facility completed an overhaul of Ongoing Professional Practice Evaluation (OPPE) forms in June 2023. The Chief of Credentialing revised and made compliant all OPPE forms with the assistance of all involved Service Chiefs. The facility has OPPE forms reviewed by providers who have a similar set of privileges. The facility has and continues to monitor 10 OPPEs per month (60 total) over the six-month period from 7/1/23 to 12/31/23 from differing specialties for confirmation that the provider completing the OPPE has similar privileges as to the one being reviewed. The facility anticipates closure in January 2024, when evidence demonstrates 90% compliance for six months.

VHA requires service chiefs to include service-specific criteria in OPPEs.[41] The OIG found that LIPs' OPPEs did not consistently have evidence of service-specific criteria, which could cause

[39] 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.

[40] 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," May 18, 2021; VHA Directive 1100.21(1).

[41] 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.

service chiefs to overlook specific practice deficiencies that could compromise patient safety. The Chief of Credentialing reported staff had revised OPPE forms to capture service-specific elements but acknowledged some chiefs used a general form instead.

Recommendation 2

2. The Chief of Staff ensures service chiefs include service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.

Medical center concurred.

Target date for completion: 1/31/2024

Medical center response: The facility completed an overhaul of OPPE forms in June 2023. The Chief of Credentialing revised and made compliant all OPPE forms with the assistance of all involved Service Chiefs. The facility has and continues to monitor 10 OPPEs per month (60 total) over the six-month period from 7/1/23 to 12/31/23 from differing specialties for confirmation that service-specific criteria is present in all OPPEs. The facility anticipates closure in January 2024, when evidence demonstrates 90% compliance for six 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 VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[42] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[43]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated.[44]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 13 patient care areas:

- Emergency Department
- Intensive care-medical/surgical unit (America Wing-6)
- Intensive care-telemetry/step-down unit (America Wing-4)
- Intensive care-telemetry/step-down unit (America Wing-6)
- Medical/surgical inpatient units (7-north, 7-south, 8-north, and 8-south)
- Mental health inpatient unit
- Primary care clinic
- Specialty clinics (3-east and 3-west)
- Women's health clinic

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

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

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

Environment of Care Findings and Recommendations

The Joint Commission requires hospital staff to establish and maintain a safe, functional environment.[45] The OIG identified a pattern of isolated deficiencies that indicated a lack of oversight and attention to detail in some clinical areas. In 6 of the 13 units inspected, the OIG found stained ceiling tiles, a soiled restroom floor, a damaged plexiglass radiator cover, a damaged stretcher, a nutrition room with water damage, an electrocardiogram machine lacking preventive maintenance, and housekeeping equipment stored in soiled utility rooms.[46]

The Deputy Chief, Quality, Safety, and Value stated the Environment of Care team provided just-in-time training to employees and supervisors on the need to place work orders immediately; however, due to the constantly changing workforce, clinical and ancillary staff did not submit timely work order requests.[47]

Recommendation 3

3. The Associate Director ensures managers maintain a safe and clean environment throughout the medical center.[48]

Medical center concurred.

Target date for completion: Completed 7/31/2023.

Medical center response: Refresher training on Environment of Care (EOC) tracer completion was provided by Quality Safety & Value (QSV) staff to leadership and management staff via QSV Committee in February 2023. Deficiencies were corrected in February 2023 and the facility has monitored deficiencies for compliance via monthly tracers over a six-month period from 2/1/2023 to 7/31/2023 from various patient care units to confirm compliance throughout the facility is maintained. Compliance of 90% for rolling six months achieved on 7/31/2023. Requesting closure.

[45] The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, EP1 and EP20, and EC.02.04.03, EP2.

[46] The OIG found deficiencies in the following areas: the Emergency Department, primary care clinic, specialty clinics 3-east and 3-west, medical/surgical units 7-north and 7-south. The 7-north nutrition room is a kitchenette with a sink, ice machine, and refrigerator to store snacks and other nutritional supplements for inpatients between meals.

[47] "Developing or making available to staff just-in-time and just-in-place learning resources that allow staff to easily access specific information at the time of need while on the job to promote fast and accurate responses on the spot, as well as serving as a resource that can be thoroughly reviewed and referenced at any time." VHA Directive 1052, *Appropriate and Effective Use of VHA Employee Mandatory and Required Training*, June 29, 2018.

[48] The OIG did not receive evidence sufficient to demonstrate leaders completed improvement actions and sustained compliance; therefore, the recommendation will remain open.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[49] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[50] The suicide rate for veterans was higher than for nonveteran adults during 2020.[51] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[52]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[53] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[54]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[55]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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

[50] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed November 30, 2022, https://www.cdc.gov/suicide/facts/index.html.

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

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

[53] 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.)

[54] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)." Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

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

Mental Health Findings and Recommendations

VHA requires providers to complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen. VHA also states that providers should complete the evaluation on the same day unless it is not clinically appropriate, such as when urgent or emergent care is needed.[56] The OIG estimated that for 28 (95% CI: 16 to 40) percent of patients with positive suicide risk screens, providers did not complete evaluations or did not complete them on the same day, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[57] When providers do not assess patients for suicidal thoughts and behaviors or evaluate them timely, they may miss signs of imminent risk. The Deputy Chief, Quality, Safety, and Value stated providers inconsistently completed the evaluation because of its length and complexity, and they prioritized other behavioral health screening tools.

Recommendation 4

4. The Chief of Staff ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a positive suicide risk screen when it is clinically appropriate.[58]

Medical center concurred.

Target date for completion: Completed 7/31/2023.

Medical center response: Refresher Suicide Prevention training to all 12 Primary Care clinics was completed via Teams from March to April 2023. The Suicide Prevention Coordinator monitored for continued compliance over a six-month period from 2/1/2023 to 7/31/2023 by reviewing daily reports, checking for date and time of Comprehensive Suicide Risk Evaluation completion. Compliance of 90% for rolling six-month period achieved 7/31/2023. Requesting closure.

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

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

[58] The OIG did not receive evidence sufficient to demonstrate leaders completed improvement actions and sustained compliance; therefore, the recommendation will remain open.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines four OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Chief of Staff and Associate Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Providers with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners. • Service chiefs include service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.
Environment of Care	• Managers maintain a safe and clean environment throughout the medical center.
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation on the same day as a positive suicide risk screen when it is clinically appropriate.

Appendix B: Medical Center Profile

The table below provides general background information for this highest complexity (1a) affiliated medical center reporting to VISN 10.[1]

Table B.1. Profile for Richard L. Roudebush VA Medical Center (583) (October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$674,109,063	$766,070,143	$802,364,379
Number of:			
• Unique patients	60,491	62,787	62,699
• Outpatient visits	671,147	769,438	744,748
• Unique employees§	2,824	2,864	2,779
Type and number of operating beds:			
• Domiciliary	50	50	50
• Medicine	83	83	83
• Mental health	15	15	15
• Rehabilitation medicine	8	8	8
• Surgery	43	43	43
Average daily census:			
• Domiciliary	40	23	42
• Medicine	63	71	63
• Mental health	12	12	13
• Rehabilitation medicine	4	5	5

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

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census, cont.:			
• Surgery	12	13	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, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 7, 2023

From: Network Director, Veterans Integrated Service Network 10 (10N10)

Subj: Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

To: Director, Office of Healthcare Inspections (54HF02)

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

1. I have reviewed and concur with the response for the draft report of our Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana.
2. I concur with the responses and action plans submitted by the Richard L. Roudebush VA Medical Center Director.
3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Laura E. Ruzick, FACHE

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: December 6, 2023

From: Director, Richard L. Roudebush VA Medical Center, Indianapolis, Indiana (583)

Subj: Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

To: Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. The facility appreciates the thoughtful and thorough evaluation of hospital operations.
2. After review we concur with all recommendations.
3. We are dedicated to continuing our efforts to provide the highest quality of care to our Veterans and building upon the insights gained from the OIG's initial recommendations.

(Original signed by:)

Michael E. Hershman, MHA, FACHE
Medical Center Director

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