US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Aleda E. Lutz VA Medical Center in Saginaw, Michigan

CHIP Report | 22-03166-88 | February 29, 2024

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Figure 1. *Aleda E. Lutz VA Medical Center in Saginaw, Michigan.*
Source: https://www.va.gov/saginaw-health-care (*accessed January 8, 2024*).

Abbreviations

ADPCS	Associate Director Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
COS	Chief of Staff
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 outpatient settings of the Aleda E. Lutz VA Medical Center, which includes multiple outpatient clinics in Michigan.[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 suicide prevention initiatives)

The OIG initiated an unannounced inspection of the Aleda E. Lutz VA Medical Center during the week of April 24, 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 Director and Chief of Staff in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; 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

[1] At the time of the OIG inspection, the Aleda E. Lutz VA Medical Center did not provide inpatient care.

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 19.

VA Comments

The Veterans Integrated Service Network Director and interim Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, page 21–22, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendation 1 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the outpatient settings of the Aleda E. Lutz VA Medical Center 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 medical center 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 suicide prevention initiatives)

[1] At the time of the OIG inspection, the Aleda E. Lutz VA Medical Center did not provide 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): 13, 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 (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Aleda E. Lutz VA Medical Center includes multiple outpatient clinics in Michigan. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review during the week of April 24, 2023.[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 medical center leaders complete corrective actions. The interim Medical Center 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 non-compliance.

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 Aleda E. Lutz VA Medical Center occurred in July 2020. The Joint Commission performed a laboratory review in July 2021, ambulatory care and behavioral health care accreditation reviews in October 2021, and a home care accreditation review in September 2021.

[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 organization's 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 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 (COS); Associate Director Patient Care Services (ADPCS); Associate Director, Operations; and Assistant Director. The COS 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 for approximately a week and included three temporarily assigned leaders. The Director was detailed to another Veterans Health Administration (VHA) facility in March 2023, and acting Director A was assigned through June 2023. The COS was also detailed to another VHA facility, and an acting COS had been serving in the role for eight days. During the OIG review, the Associate Director, Operations was serving as acting Director B during acting Director A's week-long absence, and

[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.

the Assistant Director was serving as the acting Associate Director, Operations for the on-site week.

To help assess executive leaders' engagement, the OIG interviewed acting Director B, the acting COS, ADPCS, and acting Associate Director, Operations 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 $394,218,031 had increased approximately 6 percent compared to the previous year's budget of $371,231,235.[11] The acting Associate Director, Operations stated that leaders used funds to hire staff, including nurses and medical assistants, and create an informatics service to support the scheduled implementation of Oracle Cerner.[12] The ADPCS discussed challenges with retaining nursing staff such as competition with outside VA facilities offering virtual positions and added that leaders used funds to increase salaries for nurses and offer recruitment incentives.

Leaders also expressed budgetary concerns related to patients receiving care in the community.[13] The acting Associate Director, Operations said managing patients receiving specialty care in the community was challenging, requiring staff to review patient consults and ensure care coordination. Acting Director B and acting Associate Director, Operations described strategies to reduce dependence on care in the community such as increasing staff and creating same-day walk-in access for primary care to increase availability. The acting COS added the VA's Michigan Market Referral Coordination Initiative had been successful in reducing the number of care in the community visits.[14]

---

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

[12] Oracle Cerner is the contractor to provide an electronic health record platform to VHA. VA EHR Modernization, "VA Signs Contract with Cerner for an Electronic Health Record System," news release, May 17, 2018, https://digital.va.gov/ehr-modernization/news-releases/va-signs-contract-with-cerner-for-an-electronic-health-record-system/. The medical center was scheduled to implement the new electronic health record system, Oracle Cerner, in June 2023. The implementation was postponed by VHA in April 2023. Department of Veterans Affairs, "Pause on Oracle Cerner Electronic Health Record (EHR) Rollout," news release, April 7, 2023.

[13] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care Overview," Department of Veterans Affairs, accessed October 31, 2023, https://www.va.gov/communitycare/.

[14] The Michigan Market Referral Coordination Initiative is "a market level system covering most of Michigan…[that] uses a centralized nurse driven team to manage specialty referrals…working directly with the Veteran to explore both VA and Community Care options." "Diffusion Marketplace," Department of Veterans Affairs, accessed June 15, 2023, https://marketplace.va.gov/innovations/michigan-market-referral-coordination-initiative-mmrci-a-commitment-to-offering-veterans-a-va-option-for-specialty-care-needs#overview.

Oracle Cerner Electronic Health Record Implementation

Acting Director B and acting Associate Director, Operations discussed the challenges staff experienced with the most recent postponement of the Oracle Cerner electronic health record system implementation in April 2023. In preparation for implementation, leaders and staff had conducted onboarding fairs, hired about 200 staff, and contracted an off-site center for training staff and storing the system's required equipment. The leaders described staff's commitment to the training, saying they adjusted their schedules to attend. Acting Director B and acting Associate Director, Operations reported the contract for the off-site training center expired in July 2023, and they planned to conduct a cost-benefit analysis to help decide whether to extend the contract for storing the equipment. The leaders explained they would retain the additional staff hired for implementation, anticipating staffing would return to previous levels through attrition.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[15] 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.[16] Table 1 provides relevant survey results for VHA and the medical center over time.

The medical center's All Employee Survey scores had increased over the three-year period but remained lower than VHA averages. Acting Director B and acting Associate Director, Operations attributed the improvement to leaders' increased presence in patient care areas and a commitment to frequent communication with employees and responses to their feedback, such as when leaders implement ideas that employees shared in department meetings. Acting Director B discussed the *Raise Your Mitten* program as a contributor to employees' improved feelings of psychological safety for raising concerns without fears of reprisal.[17]

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

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

[17] According to acting Director B, the *Raise Your Mitten* program allows staff to voice their concerns, recognize others, and provide recommendations to leaders; leaders review submissions and if staff provide their contact information, they will provide feedback.

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
Aleda E. Lutz VA Medical Center	3.6	3.7	3.8

Source: VA All Employee Survey (accessed November 22, 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.[18] The OIG reviewed responses to two relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022.[19] Table 2 provides survey results for VHA and the medical center over time.

The medical center's primary care scores decreased in FY 2022, indicating patients' satisfaction with their experiences declined. The ADPCS attributed the decline to employee vacancies and discussed leaders' efforts to staff primary care with well-trained providers and nurses who were responsive to patient care needs. Acting Director B and acting Associate Director, Operations attributed the decreased satisfaction to the increased use of telehealth during the COVID-19 pandemic and stated leaders were working to return patients to face-to-face care. Survey scores also indicated that patients were increasingly satisfied with their specialty care experiences. The ADPCS identified staff stability as a contributing factor.

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

[19] The Aleda E. Lutz VA Medical Center does not provide inpatient care and therefore had no inpatient survey results.

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
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	86.1	81.9	86.7	81.7	85.7
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?**	84.8	85.7	83.3	88.1	83.1	89.1

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

**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.[20] 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 and risk losing trust from patients and staff.[22]

[20] 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.

[21] 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.

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

"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)."[23] 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."[24] 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."[25] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[26]

The OIG requested a list of sentinel events and institutional disclosures that occurred during FY 2022 and reviewed the information staff provided. The Quality Safety Value Chief explained that medical center staff report adverse events through the Joint Patient Safety Reporting system, then the chief reviews them with executive leaders during daily meetings.[27] Patient safety staff described using The Joint Commission's criteria to determine whether to classify an adverse event as a sentinel event. According to quality safety value staff, when sentinel events result in major harm or death, staff follow VHA guidance, and the COS and Director determine whether the events warrant institutional disclosure.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[23] 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.

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

[25] VHA Directive 1004.08.

[26] 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.)

[27] VHA uses the Joint Patient Safety Reporting system to report patient safety events such as medical errors and close calls or near misses. "VHA National Center for Patient Safety Frequently Asked Questions," Department of Veterans Affairs, accessed January 8, 2024, https://www.patientsafety.va.gov/about/faqs.asp.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[28] 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.[29] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[30]

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.[31] 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.[32]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[33] 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."[34] 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.[35]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports.

Quality, Safety, and Value Findings and Recommendations

VHA requires staff to conduct an individual root cause analysis for adverse patient safety events assigned an actual or potential safety assessment code score of 3.[36] The OIG did not find

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

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

[30] VHA Directive 1100.16.

[31] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[33] 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.

[34] VHA Directive 1190.

[35] VHA Directive 1190.

[36] Adverse events and close calls are assigned a safety assessment code score based on the severity of the event and how often it occurs. The safety assessment code score is ranked as 3 = highest risk, 2 = intermediate risk, 1 = lowest risk. "[A] RCA [root cause analysis] is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Handbook 1050.01; VHA Directive 1050.01.

evidence staff consistently completed an individual root cause analysis for applicable adverse events that occurred in FY 2022. Lack of root cause analyses may delay the identification of system vulnerabilities that could lead to patient harm. The Patient Safety Manager attributed the noncompliance to being new in the role, not receiving the required training, and being unaware of the requirement.

Recommendation 1

1. The Director ensures staff complete individual root cause analyses for all adverse patient safety events with an actual or potential safety assessment code score of 3.[37]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Director provided National Center for Patient Safety "Foundation for Patient Safety Professional Training" for the two Patient Safety managers. Training was completed August 2023 and January 2024, each over a three-day period. 100% of Joint Patient Safety Reporting (JPSRs) were reviewed by the Patient Safety Managers (following investigation of (JPSR) to ensure an appropriate Safety Assessment Code (SAC) was entered. Then a Root Cause Analysis (RCA) was completed in accordance with the VHA National Center for Patient Safety Guide to Performing Root Cause Analysis. During FY23, 754 JPSRs were reviewed with a total of six JPSRs having a SAC score of 3 or greater necessitating an RCA to be completed in accordance with the VHA NCPS Guide to Performing RCA. All six had RCAs completed.

Evidence of compliance: FY2023 Patient Safety Annual Report and "Foundation for Patient Safety Professionals (F2F)" certificates of completion.

We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

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

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."[38] 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."[39]

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.[40] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[41]

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 an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[42]

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.[43] 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 COS. VHA also requires facilities to have credentialing and privileging managers and specialists with job duties that align under standard position descriptions.[44]

---

[38] 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.)

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Handbook 1100.19.

[42] VHA Handbook 1100.19.

[43] VHA Directive 1100.20.

[44] 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.

The OIG interviewed key managers and selected and reviewed the privileging folders of 27 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to maintain Ongoing Professional Practice Evaluation data as part of LIPs' profiles. These data may include periodic chart reviews, direct observation, and clinical discussions with other team members.[45] The OIG found that service chiefs did not consistently maintain data in LIPs' privileging folders to support Ongoing Professional Practice Evaluations. As a result, LIPs may have continued to deliver care without thorough reviews of their practices, which could adversely affect safe patient care. The Credentialing and Privileging Manager, who was appointed in June 2022, stated vacancies in the administrative officer position and turnover in the service chief position resulted in inconsistent documentation and data collection and there was no process to monitor the evaluations.

Recommendation 2

2. The Chief of Staff ensures service chiefs maintain sufficient data for licensed independent practitioners' Ongoing Professional Practice Evaluations.

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

Medical center concurred.

Target date for completion: June 30, 2024

Medical center response: The Office of the Chief of Staff and Credentialing and Privileging Service implemented new Professional Practice Evaluation (PPE) forms that include signature blocks for supervisor, provider, evaluator, and Chief of Staff. The form also currently includes a place for the Chair, Executive Committee of the Medical Staff (ECMS) to sign as well. There is also regular and recurring education with the Service Chiefs and Administrative Officers on how to properly complete and track the Ongoing Professional Practice Evaluations (OPPE). Clinical Services are responsible for training individual providers on conduction evaluations.

The facility implemented a new analyst position in Credentialing and Privileging Service to monitor and track PPE progress and data utilizing a tracking system established to capture facility-wide information. To ensure completion within 30-days of the cycle end, the analyst follows up weekly with the Administrative Officers for each service. The analyst also audits the PPE for accuracy. The data is then reported to the ECMS. PPE forms and review data are maintained on file locally within the clinical service as well as with Credentialing and Privileging Service for the duration of the providers employment.

Monitoring will be continuous and ongoing to ensure provider proficiency and a minimum of 90% compliance is maintained for six months. Monitoring results are reported to the ECMS monthly. Results of compliance will be reported every six months to the Healthcare Delivery Committee. This information is also reported weekly via the "VISN 10 Report Card."

VHA requires practitioners with equivalent specialized training and similar privileges to evaluate LIPs on an ongoing basis.[46] The OIG found that a similarly trained and privileged provider did not evaluate two of four solo LIPs.[47] This could result in the LIPs providing care without a thorough evaluation of their practices. As with the prior finding, the Credentialing and Privileging Manager attributed noncompliance to position vacancies, employee turnover, and lack of a process to monitor the evaluations.

[46] Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Indicators," May 18, 2021; VHA Directive 1100.21(1).

[47] VHA refers to a solo practitioner as being the only provider at the facility who is privileged in a particular specialty. Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Indicators."

Recommendation 3

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

Medical center concurred.

Target date for completion: June 30, 2024

Medical center response: The Chief of Staff and Credentialing and Privileging Services have implemented regular and recurring training for Service Chiefs and Administrative Officers related to ensuring practitioners with equivalent specialized training and similar privileges complete the Ongoing Professional Practice Evaluation (OPPE) of Licensed Independent Practitioners.

Implemented Professional Practice Evaluation (PPE) audits to ensure any OPPE on a solo/duo-practitioner is completed by a practitioner from another designated facility with equivalent specialized training or privileges via the VISN 10 inter-facility FPPE/OPPE SharePoint site.

Monitoring will be continuous and ongoing to ensure provider proficiency and a minimum of 90% compliance is maintained for six consecutive months. Monitoring results are reported to the ECMS monthly. Results of compliance will be reported every six months to the Healthcare Delivery Committee. This information is also reported weekly via the "VISN 10 Report Card."

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."[48] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[49]

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 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.[50]

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

- Community Living Centers (palliative care and respite care)
- Dental Clinic
- OB/GYN [Obstetrics/Gynecology]-Women's Health Clinic
- Podiatry Clinic
- Primary Care Clinic (Gold)
- Urgent Care Clinic
- Wound Clinic

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[48] 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.)

[49] 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.

[50] 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(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

Mental Health: Suicide Prevention Initiatives

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

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[55] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[56]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[57]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 48 patients who had a positive suicide screen in FY 2022 and received primary care services.

---

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

[52] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed March 10, 2022.

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

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

[55] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

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

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

Mental Health Findings and Recommendations

VHA requires designated staff to complete the Comprehensive Suicide Risk Evaluation for patients following a positive suicide risk screen.[58] The OIG determined that staff did not complete the evaluation for 40 percent of patients with a positive suicide risk screen. Failure to evaluate patients for suicidal behavior could result in missed opportunities for staff to identify patients who are at imminent risk for suicide and intervene.

The acting Associate Chief for Mental Health stated that, following a positive screen, the provider should receive a handoff from the employee who screened the patient and an alert in the electronic health record. The acting associate chief added that some providers may not have understood the requirement, received a handoff, or seen the electronic alerts. Additionally, the acting associate chief explained that other providers documented elements of the evaluation in their progress notes, so they may have believed they met the requirement.

Recommendation 4

4. The Chief of Staff ensures designated staff complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: Chief of Staff and Chief of Mental Health implemented regular and recurring education to clinical services related to completion of the Comprehensive Suicide Risk Evaluation (CSRE) following a positive Columbia-Suicide Severity Rating Scale (C-SSRS).

Implemented daily running of the CSRE fallout report at 10:00 a.m. and 2:00 p.m. to identify any same day fallouts. This report is distributed to all clinical services so follow-up CSRE can happen the same day.

Monitoring will continue until 90% compliance is maintained for six consecutive months. Monitor results are reported monthly in the RISK ID Dashboard. Results will be reported to the quarterly Mental Health Integrated Clinical Community Committee and monthly to the Quality Safety Value Committee.

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

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 Director and Chief of Staff. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• Staff complete individual root cause analyses for all adverse patient safety events with an actual or potential safety assessment code score of 3.
Medical Staff Privileging	• Service chiefs maintain sufficient data for licensed independent practitioners' Ongoing Professional Practice Evaluations. • Practitioners with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.
Environment of Care	• None
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.

Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) affiliated medical center reporting to VISN 10.[1]

Table B.1. Profile for Aleda E. Lutz VA Medical Center (655)
(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	$310,891,528	$371,231,235	$394,218,031
Number of:			
• Unique patients	36,939	38,263	40,126
• Outpatient visits	381,642	427,554	421,447
• Unique employees§	1,011	1,013	1,079
Type and number of operating beds:			
• Community living center	81	81	81
Average daily census:			
• Community living center	29	24	20

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).*

[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 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.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 16, 2024

From: Network Director, Veteran Integrated Service Network 10

Subj: Comprehensive Healthcare Inspection of the Aleda E. Lutz VA Medical Center in Saginaw, Michigan

To: Director, Office of Healthcare Inspections (54CH02)

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

1. I have reviewed and concur with the response for the Comprehensive Healthcare Inspection of the Aleda E. Lutz VAMC in Saginaw, Michigan.
2. I concur with the responses and action plans submitted by Aleda E. Lutz 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: February 15, 2024

From: Interim Director, Aleda E. Lutz VA Medical Center (655)

Subj: Comprehensive Healthcare Inspection of the Aleda E. Lutz VA Medical Center in Saginaw, Michigan

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

1. Thank you for the opportunity to review and provide a response to the findings from the draft report, Comprehensive Healthcare Inspection of the Aleda E. Lutz VA Medical Center in Saginaw, Michigan.
2. I have reviewed and concur with the recommendations in the OIG draft report. I have provided actions completed after our Comprehensive Healthcare Inspection to correct these findings with supporting documentation. Therefore, we are requesting closure for facility recommendation #1. Recommendations 2, 3, and 4, have action plans in place.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts for our Veterans.

(Original signed by:)

Carol Dopp
Interim Medical Center Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Myra Brazell, MSW, LCSW, Team Leader Barbara Miller, BSN, RN, Co-Team Leader Bruce Barnes Rose Griggs, MSW, LCSW Miquita Hill-McCree, MSN, RN Tenesha Johnson-Bradshaw, MS, FNP-C Sheeba Keneth, MSN/CNL Georgene Rea, MSW, LCSW Michael Tadych, MSW, FACHE
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Yolanda Dunmore, BA 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 Joanne Wasko, MSW, LCSW Elizabeth Whidden, MS, APRN Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)
Director, Aleda E. Lutz VA Medical Center (655)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Gary Peters, Debbie Stabenow
US House of Representatives: Jack Bergman, Dan Kildee, Lisa McClain, John Moolenaar, Elissa Slotkin

OIG reports are available at www.vaoig.gov.