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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Royal C. Johnson Veterans' Memorial Hospital in Sioux Falls, South Dakota

CHIP Report | 23-00006-03 | October 24, 2023

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Figure 1. *Royal C. Johnson Veterans' Memorial Hospital in Sioux Falls, South Dakota.*
Source: https://www.va.gov/sioux-falls-health-care/ (accessed January 11, 2023).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Royal C. Johnson Veterans' Memorial Hospital and multiple outpatient clinics in Iowa and South Dakota. 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 Royal C. Johnson Veterans' Memorial Hospital during the week of January 9, 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 hospital'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 one recommendation to the Chief of Staff in the Mental Health review area. The number of recommendations should not be used as a gauge for the overall quality of care provided at this hospital. 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 result is detailed in the report section, and the recommendation is presented in appendix A on page 16.

VA Comments

The Veterans Integrated Service Network Director and Director agreed with the comprehensive healthcare inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, pages 18–19, and the response within the body of the report for the full text of the directors' comments). The OIG considers recommendation 1 closed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Royal C. Johnson Veterans' Memorial Hospital 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 hospital 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 Royal C. Johnson Veterans' Memorial Hospital includes outpatient clinics in Iowa and South Dakota. General information about the hospital can be found in appendix B.

The inspection team conducted an on-site review beginning Monday, January 9, 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's 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 recommendation for improvement addresses a problem that can influence the quality of patient care significantly enough to warrant OIG follow-up until hospital leaders complete corrective actions. The Director's response to the report recommendation appears within the associated topic area. The OIG accepted the action plan 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 Royal C. Johnson Veterans' Memorial Hospital concluded in March 2019. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in June 2022.

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

Results and Recommendations

Leadership and Organizational Risks

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

To assess this hospital'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 hospital 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 hospital had a leadership team consisting of the Director; Chief of Staff; Associate Director, Patient Care Services; and Associate Director. The Chief of Staff and Associate Director, Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

The prior Director was detailed (temporarily assigned) to the VISN 23 office effective April 2022, and the permanent Chief of Staff was assigned as the Acting Director. The Chief of Primary Care and Community-based Outpatient Clinics was the Acting Chief of Staff. At the time of the OIG inspection, the Acting Director and Acting Chief of Staff had served in their roles since April 2022. The Associate Director, Patient Care Services and Associate Director had been in their positions since 2020.

[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 Acting Director; Acting Chief of Staff; Associate Director, Patient Care Services; and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the hospital's fiscal year (FY) 2022 annual medical care budget of $361,253,124 had increased by about 11 percent compared to the previous year's budget of $325,212,080.[10] The Acting Director reported leaders were recruiting specialty providers to return services to the hospital that were being purchased in the community.[11] The Acting Director stated there was a temporary decrease in FY 2022 full-time equivalent employees because the COVID-19 pandemic had led many staff to retire or leave the nursing field. At the time of the OIG review, the Acting Director reported that nurse staffing had increased and there was a VISN initiative to further increase staffing.

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 hospital over time.

The hospital' scores were slightly lower than VHA averages for all three years. The Associate Director discussed leaders' actions to improve scores, which included holding daily huddles to enhance information flow for staff issues and creating All Employee Survey workgroups. The Associate Director, Patient Care Services stated leaders need to listen to front-line staff. The Associate Director, Patient Care Services also reported encouraging nurse managers to share information and use quality improvement boards on units, and mentoring them on transparency principles.

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

[11] "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," Department of Veterans Affairs, accessed May 26, 2023, https://www.va.gov/communitycare/.

[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
Royal C. Johnson Veterans' Memorial Hospital	3.7	3.8	3.8

Source: VA All Employee Survey (accessed October 24, 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 hospital from FYs 2020 through 2022. Table 2 provides survey results for VHA and the hospital over time.

In FY 2021, the hospital won the VHA Most Improved in Outpatient Experience Award. To achieve this recognition, the hospital had the largest VHA-wide score improvement in the overall rating of primary care outpatient experience data in FY 2021.

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

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Hospital	VHA	Hospital	VHA	Hospital
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	76.5	69.7	82.9	68.9	78.9
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	86.7	81.9	93.6	81.7	87.6
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	88.7	83.3	91.3	83.1	92.5

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed on 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 Hospital 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.[15] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[16] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[15] 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/.

[16] 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, accessed January 8, 2023, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[17]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[18] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[19] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[20] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[21]

The OIG requested sentinel events and institutional and large-scale disclosures that occurred from October 1, 2021, through September 30, 2022, and reviewed the information staff provided. The Patient Safety Manager stated staff reviewed adverse events and reported them to executive leaders in morning meetings; for serious safety events, patient safety staff or the nurse on duty notified executive leaders immediately. The Patient Safety Manager added that leaders also reviewed close calls during morning meetings and described the hospital's *Good Catch* program in which staff who reported close calls received time off and football-shaped awards.[22] The Risk Manager spoke of reviewing patient safety events with the Chief of Staff to determine whether a disclosure was needed.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

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

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

[20] VHA Directive 1004.08.

[21] 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.)

[22] "A close call is an event or situation that could have resulted in an adverse event but did not, either by chance or through timely intervention." VHA Directive 1004.08.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[23] 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.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[25]

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.[26] 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.[27]

The OIG assessed the hospital's processes for conducting peer reviews of clinical care.[28] 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."[29] 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.[30]

The OIG team interviewed key managers and evaluated Peer Review Committee quarterly reports and patient safety reports from FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[25] VHA Directive 1100.16.

[26] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[28] 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.

[29] VHA Directive 1190.

[30] 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."[31] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[32]

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

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[35]

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

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

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Directive 1100.20.

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

The OIG interviewed key managers and selected and reviewed the privileging folders of 30 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

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

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of 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."[38] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[39]

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, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[40]

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

- Community living center (Eagles Cove)
- Emergency Department
- Intensive Care Unit
- Medical/surgical inpatient unit (3 South)
- Mental Health Inpatient Unit
- Primary Care Clinic

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[38] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (VHA amended this directive September 7, 2023).

[39] 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.

[40] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013; VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023.)

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[41] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[42] The suicide rate for veterans was higher than for nonveteran adults during 2020.[43] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[44]

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.[45] 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.[46]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator whose duties include tracking and following up with high-risk veterans, conducting community outreach activities, and informing leaders of suicide-related events.[47]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and managers 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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[41] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[42] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023, https://www.cdc.gov/suicide/facts/index.html.

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

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

[45] 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.)

[46] 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.)

[47] 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 a suicide risk evaluation for patients following a positive screen. In ambulatory care settings, staff should complete the risk evaluation on the same calendar day unless it is "not logistically feasible or clinically appropriate" such as situations where urgent or emergent care is needed.[48] The OIG estimated that staff did not complete the evaluation on the same calendar day for 26 (95% CI: 14 to 36) percent of primary care patients with a positive screen who were appropriate for same-day evaluation, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[49] Failure to complete this evaluation within the time frame poses a potential patient safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The Administrative Officer for the Chief of Staff reported that some primary care staff lacked an understanding that it was their responsibility to complete the evaluation. The Acting Chief of Staff further explained that frequent employee turnover was also a barrier because new staff were often unaware of the evaluation requirement.

Recommendation 1

1. The Chief of Staff ensures designated staff complete a Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.[50]

[48] 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)."

[49] 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.

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

Hospital concurred.

Target date for completion: Completed

Hospital response: Prior to the OIG Comprehensive Healthcare Inspection, the Suicide Prevention Coordinator (SPC) recognized that the compliance rate for completing the Comprehensive Suicide Risk Evaluation (CSRE) when a suicide screen was positive had fallen to 25% in December 2021 and took action for improvement. In January 2022, Mental Health Leadership and the SPC reviewed local processes and implemented a change in which staff reach out to Primary Care Mental Health Integration (PCMHI) if a Veteran screens positive on a suicide screen. PCMHI then triages the Veteran to ensure the CSRE was completed same day. The SPC provided training to educate on the updated local process in January 2022. The completion rate for CSRE on positive suicide screens continued to be monitored and the compliance rate remained inconsistent. In March 2022, the PCMHI Social Worker provided Risk ID discussion/education during the Patient Aligned Care Team (PACT) interdisciplinary monthly meeting. The PCMHI social worker continues to provide sporadic ongoing Risk ID education to the PACT teams to ensure sustainment. In April 2022, the CSRE completion rate reached 100%. Compliance with timely completion of the CSRE following a positive screen was monitored through the Combined National Suicide Prevention Program Metrics Dashboard. The "Summary Metrics" report on this dashboard is reviewed monthly to gather the data provided in the "RISK ID POWER BI" summary. Additionally, the "Ambulatory Risk ID" report on this dashboard was reviewed each business day by the Suicide Prevention Coordinator to ensure no CSREs were missed from the day before that need immediate follow up. The Suicide Prevention Coordinator provided a Suicide Risk ID report, which included CSRE completion compliance, to the Quality Safety Value Council (QSVC) quarterly. The Chief of Staff is a member of QSVC.

In an effort to continuously improve the process and ensure sustained compliance, the following actions have been taken. In July 2022, the PCMHI team worked with clinical staff members to establish PCMHI Teams chat groups so that all clinical staff can quickly and easily access the PCMHI team to notify them of a positive suicide screen. In October 2022, the SPC began providing one to one Risk ID training to all new mental health providers and social workers, due to these disciplines completing majority of CSREs, to ensure new staff understand the process. In August 2023, PCMHI SW [social worker] started presenting at new employee orientation to ensure and set up a PCMHI chat group for all new clinical staff members.

Since April 2022, the compliance rate for completion of the CSRE for a positive suicide screen within the required timeframe has remained at 100%. The SPC continues to monitor compliance on a daily basis.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• None
Mental Health: Suicide Prevention Initiatives	• Designated staff complete a Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

Appendix B: Hospital Profile

The table below provides general background information for this medium complexity (2) affiliated hospital reporting to VISN 23.[1]

Table B.1. Profile for Royal C. Johnson Veterans' Memorial Hospital (438) (October 1, 2019, through September 30, 2022)

Profile Element	Hospital Data FY 2020*	Hospital Data FY 2021†	Hospital Data FY 2022‡
Total medical care budget	$295,218,277	$325,212,080	$361,253,124
Number of:			
• Unique patients	27,076	27,812	28,262
• Outpatient visits	268,086	300,765	291,413
• Unique employees§	955	962	956
Type and number of operating beds:			
• Community living center	58	58	58
• Medicine	19	19	19
• Mental health	6	6	6
• Surgery	3	3	3
Average daily census:			
• Community living center	38	23	27
• Medicine	11	13	11
• Mental health	3	3	3
• Surgery	2	2	2

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 "2" indicates a facility with "medium volume, low risk patients, few 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 hospital is associated with a medical residency program. VHA Directive 1400.03*, Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 25, 2023

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

Subj: Comprehensive Healthcare Inspection of the Sioux Falls VA Health Care System in South Dakota

To: Director, Office of Healthcare Inspections (54CH03)

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

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

(Original signed by:)

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

Appendix D: Hospital Director Comments

Department of Veterans Affairs Memorandum

Date: September 21, 2023

From: Executive Director/CEO, Sioux Falls VA Health Care System (438)

Subj: Comprehensive Healthcare Inspection of the Sioux Falls VA Health Care System in South Dakota

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

1. Thank you for the opportunity to review and comment on the draft report for the Comprehensive Healthcare Inspection of the Sioux Falls VA Health Care System in Sioux Falls, South Dakota.
2. I concur with the recommendation outlined in this report and am submitting the corrective actions taken to improve our processes.
3. I appreciate the review by OIG as part of our ongoing commitment to process improvement to ensure safe and quality care to Veterans.

(Original signed by:)

Daniel B. Hubbard for
Sara S. Ackert, MHA

OIG Contact and Staff Acknowledgments

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