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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Nebraska-Western Iowa Health Care System in Omaha

CHIP Report | **23-00098-151** | **April 24, 2024**

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Figure 1. *Omaha VA Medical Center of the VA Nebraska-Western Iowa Health Care System.*

Source: https://www.va.gov/nebraska-western-iowa-health-care/ (accessed November 16, 2022).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Nebraska-Western Iowa Health Care System, which includes the Grand Island and Omaha VA Medical Centers and multiple outpatient clinics in Nebraska, as well as one outpatient clinic in Iowa. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

The OIG initiated an unannounced inspection of the VA Nebraska-Western Iowa Health Care System during the week of August 7, 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 healthcare system'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 two recommendations to the Executive Director and Chief of Staff in the Leadership and Organizational Risks and Medical Staff Privileging areas of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of

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

VA Comments

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

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Nebraska-Western Iowa Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[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 VA Nebraska-Western Iowa Health Care System includes the Grand Island and Omaha VA Medical Centers and multiple outpatient clinics in Nebraska, as well as one outpatient clinic in Iowa. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review during the week of August 7, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

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

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

[5] The OIG's last comprehensive healthcare inspection of the VA Nebraska-Western Iowa Health Care System occurred in November 2017. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in July 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 healthcare system'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 healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

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

At the time of the OIG inspection, the executive team had worked together for over one year, since the ADPC was assigned in April 2022. The Chief of Staff was the most tenured leader, having served in the position since September 2016.

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

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

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

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPC, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.[10]

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $1,731,866,382 had increased over 7 percent compared to the previous year's budget of $1,617,142,380.[11] The Director stated the budget was adequate. The Associate Director reported using funds for buying medical equipment, including two magnetic resonance imaging machines; relocating the Lincoln VA Clinic to a smaller space after the lease ended; and opening a new community living center and ambulatory care center, which required additional clinical and administrative staff.[12] The Director said the Omaha VA Medical Center is over 50 years old and therefore requires significant funding to update and maintain.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

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.[14] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

Healthcare system scores were similar to VHA's and remained stable all three FYs. The Director attributed the scores' stability to employees' focus on the high-reliability framework, including implementing staff forums and sharing lessons learned to enhance safety throughout the system.[15] The Director also described the practice of daily huddles to discuss and address

[10] At the time of the OIG inspection, the Assistant Director was temporarily assigned to VISN 23, and the Associate Director served as the acting Assistant Director.

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

[12] Magnetic resonance imaging is a noninvasive tool used to produce detailed computer-generated images of the body using magnetic fields. "MRI [magnetic resonance imaging]," Mayo Clinic, accessed November 6, 2019, https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768.

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

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

[15] A high-reliability organization is an "organization with a goal of achieving 'zero harm' in an environment where accidents are expected due to complexity or risk factors." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

problems and the integration of all employees into monthly leadership meetings, resulting in enhanced communication and transparency.

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
VA Nebraska-Western Iowa Health Care System	3.9	3.9	3.9

Source: VA All Employee Survey (accessed January 3, 2023).

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.[16] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

The healthcare system's inpatient scores indicate patients were more willing to recommend the hospital than VHA patients nationally in FYs 2020 and 2021 but less so in FY 2022. Scores for primary and specialty care show these patients' satisfaction consistently exceeded VHA patients overall. However, scores for all three survey questions generally trended down over the three FYs.

The ADPC and Associate Director explained the kitchen was temporarily closed for renovations during FY 2022, so leaders had to contract food services, which resulted in unsatisfactory food quality, portion sizes, and meal options. The Director reported establishing a multidisciplinary group focused on identifying opportunities to enhance satisfaction, such as educating providers on effective communication with patients.

[16] "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	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	79.5	69.7	72.8	68.9	68.0
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	88.1	81.9	87.1	81.7	87.0
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	90.4	83.3	87.4	83.1	88.0

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

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

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[18] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[17] 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/.

[18] The Joint Commission, *Standards Manual*, E-dition, July 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.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[19]

"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)."[20] 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."[21] 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."[22] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[23]

The Director and Chief of Staff said the Patient Safety Manager provides leaders a daily list of events from the Joint Patient Safety Reporting system.[24] The Chief of Staff stated a team of quality improvement, risk management, and patient safety staff review events and recommend sentinel event designation based on The Joint Commission's definition. Additionally, the Director reported the Chief of Staff and Risk Manager collaborate to determine whether events need an institutional disclosure.

Leadership and Organizational Risks Findings and Recommendations

VHA requires leaders to conduct an institutional disclosure when an adverse event causes or may cause the patient's death or serious injury.[25] The OIG requested a list of patient safety events,

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

[20] 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.

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

[22] VHA Directive 1004.08.

[23] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

[24] "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[25] VHA Directive 1004.08.

sentinel events, and institutional disclosures that occurred during FY 2022. The OIG identified an adverse event that met the criteria of a sentinel event but was not included in the facility's list and did not have an institutional disclosure. The OIG also found that leaders did not conduct an institutional disclosure for one sentinel event that resulted in the patient's death. Failure to disclose events may reduce patients' and families' trust in the organization. The Chief of Staff reported believing VHA recommended but did not require institutional disclosures for sentinel events.

Recommendation 1

1. The Executive Director ensures the Chief of Staff conducts institutional disclosures for applicable sentinel events.

Healthcare system concurred.

Target date for completion: August 31, 2024

Healthcare system response: The Director reviewed the recommendation and determined no additional reasons for noncompliance. The Risk Manager, Patient Safety Manager, Quality Management Officer and Accreditory-Regulatory Quality RN now meet weekly and discuss all Sentinel Events to include cross-checking with Joint Patient Safety Reports to validate that all sentinel events were discussed, and to identify possible institutional disclosures.

The Risk Manager then meets with the Chief of Staff to discuss each sentinel event and further discuss when an institutional disclosure is appropriate. A summary of each Sentinel event discussion with the Chief of Staff will be maintained by the Risk Manager. The Risk Manager will add to the quarterly report on institutional disclosures already provided to the Executive Committee of the Medical Staff (XCOM) & the Quality Safety and Value (QSV) Committee, of which the Director is included, a report of the number of sentinel events (denominator) and the number of institutional disclosures conducted aligning with each sentinel event (numerator). Monitoring will occur monthly until there is evidence of 90% compliance or greater for six consecutive months and will be reported to the Executive Committee of the Medical Staff (XCOM) & the Quality Safety and Value (QSV) Committee.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[26] 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.[27] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[28]

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.[29] 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.[30]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[31] 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."[32] 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.[33]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed four deaths that occurred within 24 hours of inpatient admission, and staff reported no suicides within seven days of discharge from the mental health inpatient unit during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[28] VHA Directive 1100.16.

[29] VHA Handbook 1050.01; VHA Directive 1050.01(1).

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

[31] 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.

[32] VHA Directive 1190.

[33] 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."[34] 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."[35]

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.[36] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[37]

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 (OPPE) to ensure the continuous delivery of quality care.[38]

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.[39] 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

[34] 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.)

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[40]

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

VHA requires service chiefs to document Focused Professional Practice Evaluation results in LIPs' profiles.[41] The OIG found inconsistent documentation of LIPs' evaluation results, which may result in insufficient evidence to support recommendations for clinical privileges. The Chief of Staff attributed the noncompliance to a lack of oversight.

Recommendation 2

2. The Chief of Staff ensures service chiefs document Focused Professional Practice Evaluation results in licensed independent practitioners' profiles.

Healthcare system concurred.

Target date for completion: August 31, 2024

Healthcare system response: The Chief of Staff evaluated this recommendation and did not identify any additional reasons for noncompliance. A Credentialing analyst was hired who tracks FPPE [Focused Professional Practice Evaluation] and OPPE for completion data, overdue reviews, and requests for FPPE extensions. FPPE/OPPE data is updated by the analyst bi-weekly and reported to the Executive Committee of the Medical Staff meeting (XCOM) monthly. Compliance will be monitored until 90% or greater compliance is achieved and sustained for six consecutive months. Compliance will be reported to the Executive Committee of the Medical Staff meeting (XCOM) monthly.

VHA requires service chiefs to incorporate specialty-specific criteria in OPPEs.[42] VHA also requires providers with equivalent specialized training and similar privileges to evaluate LIPs on an ongoing basis.[43] The OIG did not find evidence service chiefs consistently incorporated

[40] Assistant Under Secretary for Health 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.

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

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

[43] VHA Handbook 1100.19; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," May 18, 2021; VHA Directive 1100.21(1).

specialty-specific criteria in OPPEs. Additionally, the OIG was unable to determine if providers with similar training and privileges evaluated the LIPs. This may have resulted in LIPs providing care without a thorough evaluation of their competency, which could jeopardize patient safety. The Chief of Staff attributed the noncompliance to a lack of oversight of the OPPE process.

The Chief of Staff also reported staff had self-identified these issues in January 2023 and changed OPPE processes. The OIG requested and reviewed FY 2023 OPPEs of the LIPs reviewed for FY 2022 and found service chiefs had incorporated specialty-specific criteria and similarly trained and privileged providers completed the evaluations. Because leaders had already taken action to correct the deficiency, the OIG made no recommendations.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct 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."[44] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[45]

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.[46]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 12 patient care areas:[47]

- Grand Island VA Medical Center
    - Chemotherapy/Infusion Outpatient Clinic
    - Dental outpatient clinic
    - Primary care clinics (Blue and Yellow)
- Omaha VA Medical Center
    - Emergency Department
    - Intensive Care Unit
    - Medical/surgical inpatient units (5 and 6 East)

[44] 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.)

[45] 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.

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

[47] The OIG did not inspect the community living center due to active COVID-19 cases.

- Mental Health Inpatient Unit (10 West)
- Primary care clinics (Blue and Yellow)
- Women's Health Clinic

Environment of Care Findings and Recommendations

The OIG made no recommendations.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[48] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[49] The suicide rate for veterans was higher than for nonveteran adults during 2020.[50] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[51]

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.[52] 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.[53]

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.[54]

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

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

[49] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

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

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

[52] 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.)

[53] 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.)

[54] 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 the suicide prevention coordinator to report suicide-related events monthly to quality management staff and mental health leaders.[55] The OIG found that from April 1, 2022, through September 30, 2022, the Suicide Prevention Coordinator/Program Manager did not report suicide-related events monthly to mental health leaders or quality management staff. When the coordinator does not report suicide-related events, the system's mental health and quality management teams could miss opportunities to monitor at-risk patients and provide timely intervention. The Suicide Prevention Coordinator/Program Manager said staff were not aware of the monthly reporting requirement until November 2022.

The Quality Management Program Analyst stated the Suicide Prevention Coordinator/Program Manager began reporting monthly to quality management staff and mental health leaders in December 2022. The OIG requested and received meeting minutes from December 2022 through May 2023 and determined the Suicide Prevention Coordinator/Program Manager had reported suicide-related events monthly to required staff and leaders for all six months. Because the Suicide Prevention Coordinator/Program Manager demonstrated six months of sustained compliance, the OIG made no recommendation.

[55] VHA Directive 1160.07.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided two 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 healthcare system. 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 two OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Executive 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	• The Chief of Staff conducts institutional disclosures for applicable sentinel events.
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs document Focused Professional Practice Evaluation results in licensed independent practitioners' profiles.
Environment of Care	• None
Mental Health: Suicide Prevention Initiatives	• None

Appendix B: Healthcare System Profile

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

Table B.1. Profile for VA Nebraska-Western Iowa Health Care System (636) (October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$1,456,753,432	$1,617,142,380	$1,731,866,382
Number of:			
• Unique patients	56,389	65,420	71,140
• Outpatient visits	576,320	685,556	668,595
• Unique employees§	5,242	5,310	5,135
Type and number of operating beds:			
• Community living center	42	42	118
• Domiciliary	42	37	37
• Hospital	100	100	100
Average daily census:			
• Community living center	33	24	23
• Domiciliary	14	16	20
• Hospital	41	43	44

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 "1b" indicates a facility with "medium-high volume, high risk patients, many complex clinical programs, and medium-large sized research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 21, 2024

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

Subj: Comprehensive Healthcare Inspection of the NWI [Nebraska-Western Iowa] VA Health Care System in Omaha

To: Director, Office of Healthcare Inspections (54CH00)

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 NWI VA Health Care System.
2. NWI VA Health Care System has submitted the action plans and monitors to demonstrate compliance with the recommendations.
3. I concur with the recommendations and action plans outlined in this report.

(Original signed by:)

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

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 8, 2024

From: Executive Director, VA Nebraska-Western Iowa Health Care System (636)

Subj: Comprehensive Healthcare Inspection of the VA Nebraska-Western Iowa Health Care System in Omaha

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

The Nebraska-Western Iowa VA Medical Center would like to thank the Office of Inspector General team for their review. I have reviewed the report from the Comprehensive Healthcare Inspection Program and concur with the recommendations and submitted action plans.

(Original signed by:)

Eileen Kingston, DNP, MPA, BSN, RN, NE-BC
Medical Center Director

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