US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan

CHIP Report | **23-00111-119** | **April 3, 2024**

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Figure 1. *Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan. Source: https://www.va.gov/iron-mountain-health-care/locations/ (accessed July 5, 2023.)*

Abbreviations

ADNPC	Associate Director, Nursing and Patient Care
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
TJC	The Joint Commission
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 Oscar G. Johnson VA Medical Center, which includes multiple outpatient clinics in Michigan and Wisconsin. 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 Oscar G. Johnson VA Medical Center during the week of July 10, 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 one recommendation to the Veterans Integrated Service Network Director and one to the Medical Center Director in the Leadership and Organizational Risks review area, and one 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 medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results

are detailed throughout the report, and the recommendations are summarized in appendix A on page 22.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 24–25, 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.

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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 Oscar G. Johnson VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

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

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

Methodology

The Oscar G. Johnson VA Medical Center includes outpatient clinics in Michigan and Wisconsin. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review the week of July 10, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until medical center leaders complete corrective actions. The directors' 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 Oscar G. Johnson VA Medical Center occurred in January 2020. The Joint Commission (TJC) performed hospital, behavioral health care and human services, and home care accreditation reviews in February 2021.

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

Results and Recommendations

Leadership and Organizational Risks

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

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

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

Executive Leadership Position Stability and Engagement

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

At the time of the OIG inspection, the executive team had worked together since February 2023, when the Director assumed the role. However, the Chief of Staff had the longest tenure on the team and reported working with the ADNPC and Associate Director in various leadership roles since 2019.

[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, ADNPC, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $254,680,292 had increased by approximately 8 percent compared to the previous year's budget of $235,571,172.[10] The Director stated leaders spent FY 2022 funds primarily on salaries and recruitment and retention incentives. The Chief of Staff added that physician recruitment was challenging due to the medical center's rural location.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] 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.[12] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

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
Oscar G. Johnson VA Medical Center	3.9	4.0	4.0

Source: VA All Employee Survey (accessed December 27, 2022).

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

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

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

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

The medical center's scores for the selected question were higher than VHA's for all three years. The ADNPC attributed the higher scores to executive leaders' visibility through frequent visits to inpatient and outpatient areas, participation in new employee orientation, and recognition of staff who reported patient safety events. The Chief of Staff provided an example of how executive leaders recognized staff achievements using a *Bravo* card and said they signed and presented the card to employees who demonstrated excellence in areas such as integrity, respect, and patient advocacy (see figure 2).

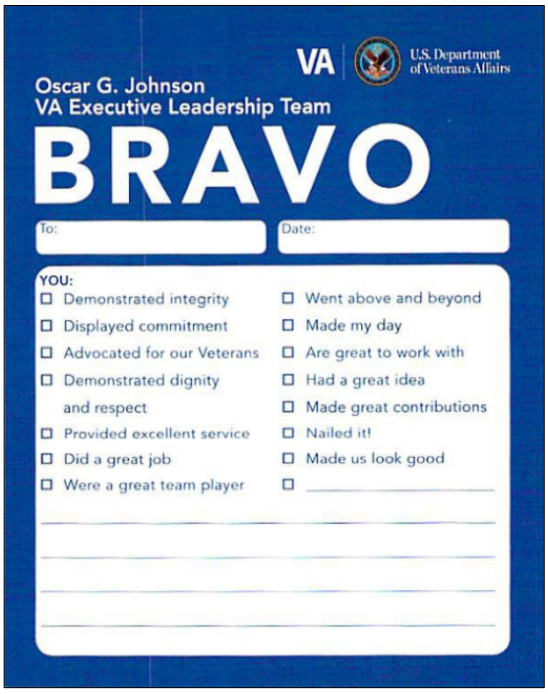

Figure 2. *Oscar G. Johnson VA Medical Center Bravo card.*

Source: Chief of Staff (received July 13, 2023).

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

Inpatient, primary care, and specialty care satisfaction scores were consistently higher than VHA averages, indicating patients were more satisfied compared to VHA patients overall. The ADNPC attributed the higher scores to staff being approachable, friendly, and engaged with patients and having a strong sense of community. The Chief of Staff stated patient satisfaction was also influenced by interactions with the patient advocates, who were available to address concerns and monitored them through resolution. The Director added that the medical center had an excellent reputation and was the primary employer in the community.

[13] "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	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	84.5	69.7	85.7	68.9	87.1
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	82.5	89.9	81.9	89.1	81.7	92.0
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	90.9	83.3	88.6	83.1	89.9

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

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[14] According to The Joint Commission's (TJC's) standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[15] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[14] 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/.

[15] TJC, *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.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[16]

"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)."[17] 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."[18] 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."[19] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[20]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022. The Risk Manager reported four sentinel events occurred during this time frame. The Chief of Quality Management said the adverse event process involves reviewing local policies and TJC guidelines to determine when adverse events meet sentinel event criteria. The Risk Manager described communicating sentinel events to the Chief of Quality Management, who then elevates the information to executive leaders during morning meetings. The Chief of Quality Management said executive leaders conduct institutional disclosures for all sentinel events. The Chief of Staff added that the institutional disclosure process is an opportunity to meet with a patient, family member, or both to offer an apology or discuss an alternative treatment option. The Risk Manager reported executive leaders conducted six institutional disclosures in FY 2022 and that no adverse events met criteria for large-scale disclosures.

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

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

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

[19] VHA Directive 1004.08.

[20] 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.)

Leadership and Organizational Risks Findings and Recommendations

The VHA National Center for Patient Safety and TJC recognize home oxygen fires as sentinel events.[21] When sentinel events occur, TJC requires staff to "complete a thorough comprehensive systematic analysis (most commonly a root cause analysis) to determine why the event occurred" within "45 business days of the event or of becoming aware of the event."[22] Finally, VHA requires the VISN director to ensure VA medical facilities and programs maintain continuous compliance with TJC standards.[23]

During the inspection week, the OIG identified an event involving a patient burned from a home oxygen fire. The OIG determined that medical center staff did not identify this as a sentinel event, which could delay follow-up and place patients at risk for similar adverse events in the future. The Patient Safety and Risk Managers stated they were not aware the VHA National Center for Patient Safety identified home oxygen fires as sentinel events. The Chief of Quality Management also reported being unable to determine why the prior Patient Safety Manager, who was in the position at the time of the event, did not identify the incident as a sentinel event.

Additionally, the OIG determined VISN leaders failed to provide vendor oversight for this sentinel event. The Chief of Quality Management, Risk Manager, and VISN Outpatient Respiratory Program Coordinator confirmed that VISN staff managed the home oxygen contract. The OIG reviewed the contract and determined the vendor was TJC accredited, required to provide patient education, and responsible for completing a root cause analysis for sentinel events.[24] The OIG also determined that the VISN Outpatient Respiratory Program Coordinator had notified the vendor about the fire on May 26, 2022. Despite the VISN Home Respiratory Supervisor reporting the vendor completed a root cause analysis, the OIG found, after asking to review the analysis, that the vendor completed only an incident report that was dated the week of the OIG site visit in July 2023. Failure to identify sentinel events and conduct root cause analyses may limit both VISN and medical center leaders' awareness of system vulnerabilities that could lead to patient harm. The VISN Home Respiratory Supervisor said they tracked events until actions were completed but confirmed there was no formal process to ensure the home oxygen vendor completed a root cause analysis.

[21] VHA National Center for Patient Safety, *Guidance Relating to Patient Safety Analyses of Home Oxygen Fires*, May 28, 2021; TJC, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE).

[22] TJC, *Comprehensive Accreditation Manual for Hospitals.* "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 National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, March 2023.

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

[24] VHA National Center for Patient Safety, *Guidance Relating to Patient Safety Analyses of Home Oxygen Fires*.

Recommendation 1

1. The Medical Center Director ensures staff identify sentinel events and take appropriate action when home oxygen fires occur.[25]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Director has evaluated and determined no additional reasons for noncompliance. The Director ensures that all sentinel events are identified, and appropriate action taken, including for all home oxygen fires that occur. The Iron Mountain Home Oxygen Coordinator may receive notification of home oxygen fires through various channels, including but not limited to Veterans Integrated Service Network (VISN) 12 Prosthetics staff, community clinicians, or from the vendor themselves. Upon notification of a home oxygen fire, the Iron Mountain Home Oxygen Coordinator will enter a Joint Patient Safety Report (JPSR) for the event and ensures communication with the vendor if received through a different channel. Home oxygen fires are considered sentinel events and therefore must receive an actual Safety Assessment Code (SAC) score of 3, in addition to checking the "sentinel event" box in the JPSR system. The Patient Safety Manager (PSM) reviews, evaluates, and scores all events using a SAC score of 3 for all home oxygen fires and marks the JPSR as "sentinel."

The Chief, Quality Management reviewed a monthly report from JPSR of all actual SAC 3 events to ensure they were identified as sentinel events and appropriate actions were taken. During the last seven months, one home oxygen fire occurred. The Iron Mountain Home Oxygen Coordinator was notified via email by the vendor of the occurrence with a Priority Patient Concern (PPC). They were also alerted to the event through Computerized Patient Record System (CPRS) by the VISN 12 Prosthetic Clerk of the occurrence. The Iron Mountain Home Oxygen Coordinator entered a JPSR for the event. The PSM reviewed, appropriately SAC scored, and marked the event as "sentinel."

Compliance is measured by the number of appropriate actions taken for sentinel events reported. The numerator equals the number of actual SAC 3 events identified as sentinel with appropriate actions. The denominator equals the total number of actual SAC 3 events reported in JPSR. Compliance has been reported at least quarterly to the Quality & Patient Safety Board until six consecutive months of 90% or greater compliance is achieved. Since starting this monthly review, compliance of greater than 90% has been demonstrated for seven consecutive months as shown below.

August 2023: 2/2 = 100%

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

September 2023: 0/0 = 100%

October 2023: 1/1 = 100%

November 2023: 0/0 = 100%

December 2023: 2/2 = 100%

January 2024: 1/1 = 100%

February 2024: 0/0 = 100%

Recommendation 2

2. The Veterans Integrated Service Network Director ensures network staff track and monitor home oxygen vendor completion of root cause analyses when sentinel events occur.

Veterans Integrated Service Network concurred in principle.

Target date for completion: September 30, 2024

Veterans Integrated Service Network response: The VISN 12 vendor for home oxygen is independently accredited by The Joint Commission and must maintain accreditation. According to the contract, VISN 12 does not have the authority to request the Root Cause Analysis document from the Home Oxygen vendor. However, VISN 12 has implemented a new process as of 1st Quarter. FY 2024 to ensure oversight of sentinel events related to home oxygen fires. The VISN Patient Safety Officer (PSO) and the VISN Home Oxygen Contracting Officer (COR)/Program Analyst reconcile sentinel events that involve a fire in the home of all patients on home oxygen contracted through the VISN 12 home oxygen vendor to ensure events are entered in VA Joint Patient Safety Reporting System (JPSR). The Facility Patient Safety Manager classifies sentinel events related to home oxygen in the VA JPSR in accordance with VA guidelines. The VISN PSO reviews these events to ensure appropriate classification. The VISN PSO and Home Oxygen COR/Program Analyst reconcile sentinel events reported through the VISN Home Oxygen Program to validate there is an associated safety report and Root Cause Analysis (RCA). The VISN 12 Contracting Officer (COR) for the outpatient respiratory program and program analyst ensures the vendor sends confirmation of vendor RCA completion for sentinel events related to VA contracted home oxygen.

All Sentinel events related to home oxygen will have confirmation from VISN 12 contract vendor that RCA was completed.

Sentinel event data, including those related to home oxygen fires, is reported to the VISN 12 Quality and Patient Safety Committee semi-annually.

FY23 Quarter 4 (Q4):

Numerator = 0 sentinel event related to home Oxygen fire where vendor confirmed completion of RCA

Denominator = 0 sentinel event related to home oxygen fire occurred in VISN 12

FY24 Quarter 1 (Q1):

Numerator = 1 sentinel event related to home Oxygen fire where vendor confirmed completion of RCA

Denominator = 1 sentinel event related to home oxygen fire occurred in VISN 12

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 TJC 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 TJC 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 medical center'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 reviewed relevant documents.

Quality, Safety, and Value Findings and Recommendations

At the time of the inspection, VHA required the patient safety manager to communicate adverse patient safety events entered in the Joint Patient Safety Reporting system to executive leaders "within 24 hours during the weekday and 72 hours over the weekend and holidays."[34] Through interviews, the OIG found the Patient Safety Manager did not report patient safety events to executive leaders as required in FY 2022. The Risk Manager and the Chief of Quality

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

[27] VHA Directive 1100.16.

[28] VHA Directive 1100.16.

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

[30] TJC, *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.

[34] VHA National Center for Patient Safety, *Guidebook for JPSR [Joint Patient Safety Reporting] Business Rules and Guidance*, November 2021.

Management reported being unaware of the requirement. The OIG did not issue a recommendation because VHA updated the *Joint Patient Safety Reporting Guidebook* in December 2022, allowing the patient safety manager to determine "what is appropriate regarding report type, and frequency" of safety event communication to leaders.[35] However, the OIG cautions that when staff do not report adverse events promptly to executive leaders, there can be delays in identifying quality of care and patient safety process improvements.

[35] VHA National Center for Patient Safety, *JPSR Guidebook*, December 2022.

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."[36] 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."[37]

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.[38] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[39]

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.[40]

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.[41] 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

[36] 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.)

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[42]

The OIG interviewed key managers and selected and reviewed the privileging folders of 17 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[42] 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."[43] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[44]

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.[45]

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

- Community living center (Freedom Lane)
- Medical/surgical inpatient unit (4 East)
- Primary Care Clinic
- Urgent Care Center

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[43] 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.)

[44] 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.

[45] 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.) The Oscar G. Johnson VA Medical Center did not have an inpatient mental health unit at the time of this review.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[46] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[47] The suicide rate for veterans was higher than for nonveteran adults during 2020.[48] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[49]

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.[50] 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.[51]

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.[52]

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

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

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

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

[50] 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.)

[51] 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.)

[52] 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 Recommendation

In ambulatory care settings, VHA requires designated staff to complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen. Staff should complete the evaluation on the same calendar day unless it is "not logistically feasible or clinically appropriate," such as in situations where urgent or emergent care is needed.[53] In these situations, once staff confirms patient safety, they should complete the evaluation within 24 hours of the positive screen.[54] The OIG estimated staff did not complete the evaluation on the same day for 39 (95% CI: 26 to 52) percent of patients who had a positive screen in situations clinically appropriate for a prompt evaluation, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[55] Failure to complete the evaluation on the same day as a positive suicide screen poses a safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result.

The Acting Chief of Primary Care reported vulnerabilities with the screening tool and said providers did not receive a notification for positive screens, explaining that instead, they became aware of screening results either through a warm handoff from the nurse or by reviewing the nursing documentation before assessing the patient.[56] The Chief of Mental Health acknowledged providers may have been unaware of positive screens because staff communication issues sometimes occurred during the handoff process. The Acting Chief of Primary Care also reported believing that despite providers failing to complete the evaluations, they clinically assessed the patients and found them to be safe.

The Chief of Mental Health further stated that in September and October 2022, the medical center's mental health team and information technologists discussed adding an alert to notify providers when the screen was positive. The Chief of Mental Health explained they had halted discussions due to the anticipated implementation of a new VHA electronic health record system

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

[54] 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)."

[55] 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.

[56] "A warm handoff is a transfer of care between two members of the health care team." "Warm Handoff: Intervention," Agency for Healthcare Research and Quality, accessed July 27, 2023, https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html.

and discussions had not yet resumed; however, they planned to continue reviewing possible modifications to improve alert notifications for positive screens.[57]

Recommendation 3

3. The Chief of Staff ensures designated staff complete the 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.

[57] VHA paused the national implementation of a new electronic health record system, so it did not occur as planned.

Medical center concurred.

Target date for completion: August 1, 2024

Medical center response: The Chief of Staff will ensure designated staff complete the Comprehensive Suicide Risk Evaluation (CSRE) on the same calendar day as a positive suicide risk screen unless it is not logistically feasible or clinically appropriate. The Chief of Mental Health and information technologists implemented a flag, which is a pop-up notification or alert to any clinician who opens the record, in the Computerized Patient Record System (CPRS) that provides notifications to providers of positive Suicide Risk Screenings to improve provider's awareness of positive results that require a CSRE to be completed same calendar day. This was implemented in August 2023. The Chief of Mental Health developed a guide and flow map for staff in the ambulatory setting to serve as reference for how to complete the steps for suicide screening. This was disseminated out to staff in October 2023. Additionally, to ensure the safety for all patients who screen positive on a suicide risk screen, the Suicide Prevention team reviews the Risk ID Fall Outs report, a report that shows any patient who screened positive but did not receive a comprehensive screen, daily during business hours for any CSRE assessment fall outs. Upon finding a fall out, the Suicide Prevention Team reviews the chart and consults with associated providers to facilitate a CSRE, if feasible and clinically appropriate, by the provider. The Chief, Quality Management, utilizing the National Columbia Suicide Severity Rating Scale (C-SSRS) report from Corporate Data Warehouse, will review all positive suicide risk screens to monitor compliance with timely completion of CSRE on a monthly basis. Compliance will be measured by the number of patients with a same day CSRE completed following a positive suicide risk screening. The numerator will equal the number of records with a same day CSRE completed following a positive suicide risk screen. The denominator will equal the total number of records with a positive suicide risk screen. Compliance will be reported at least quarterly to the Quality & Patient Safety Board until six consecutive months of 90% or greater compliance is achieved. Since completion of all actions, compliance has greatly improved and is demonstrated for three consecutive months as shown below.

November 2023: 16/17 = 94.1%

December 2023: 12/13 = 92.3%

January 2024: 12/13 = 92.3%

February 2024: 15/17 = 88.2%

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 three 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 three OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Veterans Integrated Service Network Director, Medical Center 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	• Staff identify sentinel events and take appropriate action when home oxygen fires occur. • The Veterans Integrated Service Network Director ensures network staff track and monitor home oxygen vendor completion of root cause analyses when sentinel events occur.
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• None
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the 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: Medical Center Profile

The table below provides general background information for this low complexity (3) affiliated medical center reporting to VISN 12.[1]

Table B.1. Profile for Oscar G. Johnson VA Medical Center (585)
(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	$203,610,942	$235,571,172	$254,680,292
Number of:			
• Unique patients	20,372	20,630	21,891
• Outpatient visits	197,284	237,668	224,757
• Unique employees§	583	620	623
Type and number of operating beds:			
• Community living center	38	38	38
• Medicine	17	17	17
Average daily census:			
• Community living center	29	24	28
• Medicine	4	4	4

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: March 5, 2024

From: Director, VA Great Lakes Health Care System (10N12)

Subj: Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan

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

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

1. I have reviewed the Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan.
2. I concur with the findings and recommendations proposed for recommendations 1 and 3. I concur in principle with the findings and recommendations for recommendation 2.
3. I concur with the submitted action plans from the facility.
4. I would like to thank the OIG Inspection team for a thorough review of the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan.

(Original signed by:)

Daniel S. Zomchek, Ph.D., FACHE
Network Director, VISN 12

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 23, 2024

From: Director, Oscar G. Johnson VA Medical Center (585)

Subj: Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan

To: Director, VA Great Lakes Health Care System (10N12)

1. Thank you for the opportunity to review the draft report of the Oscar G. Johnson VA Medical Center Hospital inspection. I have reviewed the document and concur with the recommendations.
2. A corrective action plan has been implemented as detailed in the attached report. If additional information is needed, please contact the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan.

(Original signed by:)

John P. Shealey DBA, MBA, MHA
Medical Center Director

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