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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho

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Figure 1. *Boise VA Medical Center in Idaho.*
Source: https://www.va.gov/boise-health-care/ (*accessed May 8, 2023*).

Abbreviations

ADPCS/CNE	Associate Director for Patient Care Services/Chief Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Boise VA Medical Center and multiple outpatient clinics in Idaho and Oregon. 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 Boise VA Medical Center during the week of April 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 four recommendations to the Medical Center Director in the Environment of Care and Mental Health areas of review. 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 25–26, 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 Boise 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 Boise VA Medical Center includes multiple outpatient clinics in Idaho and Oregon. General information about the medical center can be found in appendix B.

The OIG inspected the Boise VA Medical Center during the week of April 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 Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for 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 Boise VA Medical Center occurred in September 2020. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in December 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 for Patient Care Services/Chief Nurse Executive (ADPCS/CNE), and Associate Medical Center Director (Associate Director). The Chief of Staff and ADPCS/CNE 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 about three years. The Director, assigned in April 2012, was the most tenured. The Chief of Staff and Associate Director had been in their positions since October 2016 and June 2017, respectively. The ADPCS/CNE joined the team in April 2020.

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

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

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

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPCS/CNE, 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 $441,585,020 had increased by over 9 percent compared to the previous year's budget of $404,256,372.[10] The Director and Associate Director agreed that the budget was adequate and was spent on operational needs. The Director reported an increase in the veteran population in the area. As an example of responding to increased demand, both the Director and Associate Director highlighted the recently built Caldwell VA Clinic, scheduled to open in August 2023, that is 10,000 square feet larger than the previous building. In addition, the Director reported spending about $5 to $7 million of unused VISN funds to purchase medications in advance to have available when needed.

When the OIG asked about staffing, the Senior Strategic Business Partner stated the following positions were difficult to fill: physicians, registered and licensed practical nurses, medical instrument technicians, nursing assistants, police officers, custodial workers, and medical support assistants. In addition, the Senior Strategic Business Partner discussed using recruitment and retention incentives such as education debt reduction and flexible work schedules but added that some potential employees declined job offers due to uncompetitive VA salaries and rising housing costs in the area. The ADPCS/CNE expressed concerns about the inability to maximize community living center bed capacity due to the length of time it takes to onboard new staff. The Associate Director reported believing the difficulties with hiring may put the medical center at risk for additional staffing shortages.

Executive leaders discussed registered nurse turnover as a major issue, especially in the intensive care and intermediate care units, neurology service, and Emergency Department, and that recruiting and retaining nurses has been a challenge since the COVID-19 pandemic. To retain registered nurses, the Director and ADPCS/CNE described implementing an alternative work schedule in April 2022 for nurses assigned to the intensive care and intermediate care units. The ADPCS/CNE said the change in work hours decreased the intensive care nurse turnover rate.

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

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

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

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.

The medical center's scores were higher than VHA averages for all three years. The ADPCS/CNE reported believing leader visibility and meaningful communication with employees had a positive impact on the scores. Executive leaders stated employees are encouraged to report patient safety issues and that reporting is nonpunitive.

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

All Employee Survey	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Boise VA Medical Center	4.0	4.1	4.1

Source: VA All Employee Survey (accessed November 22, 2022).

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

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[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.

The medical center's survey scores indicate that patients' satisfaction with their inpatient and specialty care experiences decreased over all three years. The executive leaders reported believing increased noise on inpatient units due to construction and moving inpatient staff to different areas during the pandemic contributed to the decrease. The Director and Chief of Staff reported the year-long preparation to implement the new VA electronic health record system

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

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

(Oracle Cerner), which included staff training and clinic cancellations, had a negative impact on patient appointment availability. The Director acknowledged challenges with primary care provider turnover and recruitment due to competition from two other hospitals in the Boise area. The Chief of Staff added that challenges with recruiting and retaining psychiatrists negatively affected continuity of care and patient access.

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	80.9	69.7	79.6	68.9	75.0
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	84.4	81.9	86.5	81.7	82.0
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	88.2	83.3	86.0	83.1	84.7

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

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[14] According to The Joint Commission's standards for leadership, a culture of safety and continual process

[14] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

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 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 disclosures that occurred during FY 2022 and reviewed the information staff provided. Executive leaders discussed reviewing adverse patient safety events from the Joint Patient Safety Reporting system with quality

[15] 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.

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

[17] 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.

[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.)

management staff.[21] The Director added that quality management staff were responsible for tracking all recommended improvement actions resulting from root cause analyses.[22]

The Chief of Staff reported being responsible for the institutional disclosure process and after an institutional disclosure, the Risk Manager followed up with the patient or patient's representative for any questions related to information discussed during the process.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[21] The Joint Patient Safety Reporting system is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *Guidebook for JPSR [Joint Patient Safety Reporting] Business Rules and Guidance*, November 2021.

[22] A 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 Directive 1050.01(1).

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[23] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[25]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[26] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[27]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[28] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[29] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[30]

The OIG team interviewed key managers and staff and reviewed relevant documents. The team also reviewed patient safety reports, nine Level 3 peer reviews, five unexpected deaths that occurred within 24 hours of inpatient admission, and one suicide that occurred within seven days of discharge from an inpatient mental health unit during FY 2022.[31]

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[25] VHA Directive 1100.16.

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

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

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

[29] VHA Directive 1190.

[30] VHA Directive 1190.

[31] A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently." 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."[32] 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."[33]

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

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.[36]

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.[37] 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

[32] 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.)

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[38]

The OIG interviewed key managers and selected and reviewed the privileging folders of 28 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[38] 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."[39] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[40]

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.[41]

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

- Community living center (Aspen House)
- Emergency Department
- Inpatient Psychiatry Unit (2P)
- Intensive care unit (medical/surgical)
- Medical surgical unit (2MS)
- Primary care clinic (Silver Team)
- Women's Wellness Center

[39] 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.)

[40] 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.

[41] 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.)

Environment of Care Findings and Recommendations

At facilities with mental health inpatient units, VHA requires staff to perform systematic environmental assessments using the Mental Health Environment of Care Checklist to identify and address patient safety risks.[42] Checklist criteria state that staff test panic alarms at least quarterly and document testing and police response times in a log.[43] The OIG reviewed the log for panic alarm testing that occurred in the Inpatient Psychiatry Unit from January through March 2023 and found staff tested panic alarms but did not document police response times. Failure to document police response times may place patients, visitors, and staff at risk in the event of an actual emergency. The Chief of Police reported not consistently monitoring and documenting VA police response times because the Inpatient Psychiatry Unit is located only one floor above the police department. In addition, during the OIG inspection, the Chief of Police reported testing panic alarms on April 12, 2023, with a response time of 38 seconds.

Recommendation 1

1. The Medical Center Director ensures staff document VA police response times to panic alarm testing in the Inpatient Psychiatry Unit.

[42] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

[43] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," April 10, 2023.

Medical center concurred.

Target date for completion: October 31, 2024

Medical center response: The Medical Center Director and the facility Chief, Police Service evaluated the finding and did not identify any additional reasons for the reported failure. On April 12, 2023, while the Office of Inspector General was on site, the facility Chief, Police Service implemented a new process to document Veterans Administration Police response times on an Inpatient Psychiatry Unit panic alarm response time tracking log.

In March 2024, the facility Accreditation Manager will initiate monthly auditing to monitor compliance with Veterans Administration Police conducting panic alarm testing on the Inpatient Psychiatry Unit and documenting Veterans Administration Police response time in the response time tracking log. Compliance for this audit is measured with a denominator definition of 'the total number of Inpatient Psychiatry Unit panic alarm tests completed in the quarter.' The numerator definition is 'the total number of Inpatient Psychiatry Unit panic alarm tests that includes Veterans Administration Police response times documented in the response time tracking log.' The goal is to achieve 90 percent or greater compliance, then monitor for six consecutive months to demonstrate sustainment.

The facility Accreditation Manager will report results of the audit to the Quality and Safety Council. The Quality and Safety Council is an executive council of which the Medical Center Director is a member. The Accreditation Manager will continue to monitor monthly compliance and report results quarterly to the Quality and Safety Council until goal achieved.

Mental Health Environment of Care Checklist criteria require staff to check all over-the-door alarms on corridor doors to patient sleeping rooms "according to the manufacturer's guidelines to make sure they are still working properly."[44] The manufacturer of the installed devices recommends staff check each door alarm on a regular basis. The Chief, Biomedical Engineering reported staff checked over-the-door alarms monthly. The OIG found no evidence staff consistently checked the alarms in the Inpatient Psychiatry Unit. When staff fail to ensure door alarms work properly, they may not be alerted when a patient emergency occurs. The Chief, Biomedical Engineering explained that during the transition from one electronic preventive maintenance system to another, staff either did not initiate work orders for the alarms or did not enter them correctly.

[44] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist."

Recommendation 2

2. The Medical Center Director ensures staff follow the manufacturer's guidelines for checking over-the-door alarms for patient sleeping rooms in the Inpatient Psychiatry Unit.

Medical center concurred.

Target date for completion: October 31, 2024

Medical center response: The Medical Center Director and the facility Biomedical Engineer evaluated the finding and did not identify any additional reasons for the reported failure. On April 11, 2023, while the Office of Inspector General was on site, the Biomedical Engineer conducted an investigation and identified that the electronic preventive maintenance system that is used to generate and track work orders needed to be updated to include the over-the-door-alarms on corridor doors to patient sleeping rooms located on the Inpatient Psychiatry Unit. The system was updated on April 11, 2023, and now automatically generates work orders for Biomedical staff to complete preventive maintenance on the Inpatient Psychiatry Unit over-the-door-alarms once a month. Manufacturer recommends testing at regularly scheduled intervals.

In March 2024, the facility Accreditation Manager will initiate auditing to monitor compliance that monthly preventive maintenance of the over-the door-alarms for patient sleeping rooms in the Inpatient Psychiatry Unit are completed and documented in the electronic preventive maintenance system. Compliance for this audit is measured with a denominator definition of 'the total number of over-the-door alarms on the Inpatient Psychiatry Unit that require checking in the month.' The numerator definition is 'the total number of over-the-door-alarms checked on the Inpatient Psychiatry Unit each month.' The goal is to achieve and then sustain 90 percent or greater compliance for six consecutive months.

The facility Accreditation Manager will report the results of the audit to the Quality and Safety Council. The Quality and Safety Council is an executive council of which the Medical Center Director is a member. The Accreditation Manager will continue to monitor monthly compliance and report results quarterly to the Quality and Safety Council until goal achieved.

Mental Health: Suicide Prevention Initiatives

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

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.[49] 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.[50]

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.[51]

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

[46] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed February 15, 2023.

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

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

[49] 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.)

[50] 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.)

[51] 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, which include attempts and deaths, monthly "to local mental health leadership and quality management."[52] The OIG reviewed Mental Health Environment of Care Sub-Committee meeting minutes for FY 2022 and did not find evidence the Suicide Prevention Coordinator reported suicide-related events. When suicide-related events are not reported, mental health leaders and quality management staff may miss opportunities to mitigate safety risks to patients and employees. The Suicide Prevention Coordinator reported usually discussing suicide-related events at the monthly Mental Health Environment of Care Sub-Committee meeting in which mental health leaders and quality management staff are in attendance.

Recommendation 3

3. The Medical Center Director ensures the Suicide Prevention Coordinator reports suicide-related events to mental health leaders and quality management staff at least monthly.

[52] VHA Directive 1160.07.

Medical center concurred.

Target date for completion: October 31, 2024

Medical center response: The Medical Center Director and the facility Suicide Prevention Coordinator evaluated the finding and did not identify any additional reasons for the failure. Starting in October 2023, the facility Suicide Prevention Coordinator implemented processes to report suicide-related event data to mental health leaders and quality management staff. Once per month the Suicide Prevention Coordinator submits a report with suicide-related event data to the Quality and Safety Council. The Quality and Safety Council is an executive council of which the facility Chief, Quality and Performance Improvement, Associate Chief of Staff, Behavioral Health, and the Medical Center Director are members. Additionally, the Suicide Prevention Coordinator distributes a copy of the suicide-related event data report by email to the Behavioral Health Leadership (Associate Chief of Staff, Behavioral Health, Chief, Psychiatry, Chief, Psychologist and Chief, Social Work) monthly.

In October 2023, the facility Accreditation Manager initiated two monthly audits to monitor compliance with the Suicide Prevention Coordinator reporting/emailing suicide-related event data monthly to Quality and Safety Council and Behavioral Health Leadership. The first audit monitors compliance with the Suicide Prevention Coordinator reporting suicide-related event data to the Quality and Safety Council. Compliance for this audit is measured with a denominator definition of 'total number of suicide-related events that occurred each month.' The numerator definition is the 'total number of suicide-related events reported to the Quality and Safety Council in the month.' The second audit monitors compliance with the Suicide Prevention Coordinator distributing suicide-related event data to Behavioral Health Leadership monthly by email. Compliance for this audit is measured with a denominator definition of 'total number of suicide-related events that occurred each month.' The numerator definition is 'the total number of suicide-related events reported by email to Behavioral Health Leadership in the month.' The goal for both audits is to achieve and then sustain 90 percent or greater compliance for six consecutive months.

The facility Accreditation Manager will report the audit results to the Quality and Safety Council. The facility Accreditation Manager will continue to monitor monthly compliance and report results quarterly to the Quality and Safety Council until goal achieved.

VHA requires providers to complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen.[53] The OIG estimated that providers did not complete the evaluation after a positive screen for 66 (95% CI: 52 to 78) percent of patients, which is statistically

[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)."

significantly above the OIG's 10 percent deficiency benchmark.[54] Failure to complete the Comprehensive Suicide Risk Evaluation poses a safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The Associate Chief of Staff, Behavioral Health explained that, in many cases, providers evaluated the patient's suicide risk but documented the evaluation in their progress note rather than the required template.

Recommendation 4

4. The Medical Center Director ensures providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.

[54] 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.

Medical center concurred.

Target date for completion: December 31, 2024

Medical center response: The Medical Center Director, Associate Chief of Staff, Behavioral Health, Associate Chief of Staff, Primary Care, and the facility Suicide Prevention Coordinator evaluated the finding and identified that additional training was needed to educate staff that following any positive screen using the Columbia Suicide Severity Rating Scale, a comprehensive evaluation must be completed and documented using the national Comprehensive note Suicide Risk Evaluation template.

In May 2023, the Suicide Prevention Coordinator in collaboration with the Accreditation Manager developed single point lesson documents to be used for staff education on the correct process and required documentation following a positive suicide screen in Primary Care. Using the single point lesson documents, the Associate Chief of Staff, Primary Care, Associate Chief Nurse, Primary Care, the Nurse Clinic Managers for Primary Care and Psychologist for Behavioral Health Integrated Care Team provided face-to-face training or self-directed training with staff attestation of completion. Education was initiated beginning June 1, 2023, and was completed by August 1, 2023, for providers and nursing staff in Primary Care and the Behavioral Health Integrated Care Team.

Starting April 2024, implementation of a suicide risk screen monitoring pop-up notification and real-time report will allow the Suicide Prevention Team to initiate daily compliance monitoring of staff completing and documenting Comprehensive Suicide Risk Evaluation in a timely manner. Comprehensive Suicide Risk Evaluation adherence and fallout data will be tracked, trended, and documented using an Excel spreadsheet created and maintained by the facility Suicide Prevention Coordinator. Fallouts are communicated to the responsible provider when identified to provide re-education on timely completion. Evaluations are completed when clinically appropriate.

The numerator definition is ‘the number of patients who received a Comprehensive Suicide Risk Evaluation the same day as their positive suicide screening each month in an outpatient setting when clinically appropriate’ and the denominator is ‘total number of patients who had a positive suicide screen in the outpatient setting each month.’ The Suicide Prevention Coordinator will track, trend, and document Comprehensive Suicide Risk Evaluation compliance monthly. Due to the low numbers of Comprehensive Suicide Risk Evaluations monthly the results will be calculated monthly then collated quarterly. The collated quarterly results will be reported to the facility Accreditation Manager each quarter. The goal is to achieve 90 percent compliance or greater, then monitor for two consecutive quarters to demonstrate sustainment.

The facility Accreditation Manager will report compliance data to the Quality and Safety Council (members include the Medical Center Director, Associate Chief of Staff, Behavioral Health, and the Associate Chief of Staff, Primary Care) quarterly until goal achieved.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• Staff document VA police response times to panic alarm testing in the Inpatient Psychiatry Unit. • Staff follow the manufacturer's guidelines for checking over-the-door alarms for patient sleeping rooms in the Inpatient Psychiatry Unit.
Mental Health: Suicide Prevention Initiatives	• The Suicide Prevention Coordinator reports suicide-related events to mental health leaders and quality management staff at least monthly. • Providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.

Appendix B: Medical Center Profile

The table below provides general background information for this medium complexity (2) affiliated medical center reporting to VISN 20.[1]

Table B.1. Profile for Boise VA Medical Center (531)
(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	$363,072,519	$404,256,372	$441,585,020
Number of:			
• Unique patients	43,188	52,593	54,405
• Outpatient visits	398,727	471,041	422,206
• Unique employees§	1,391	1,507	1,550
Type and number of operating beds:			
• Community living center	32	32	32
• Domiciliary	18	18	18
• Medicine	25	25	25
• Mental health	9	9	9
• Surgery	7	7	7
Average daily census:			
• Community living center	21	16	17
• Domiciliary	11	9	1
• Medicine	22	28	28
• Mental health	4	4	4

[1] VHA medical facilities are classified according to a complexity model; a designation of "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census, cont.:			
• Surgery	3	4	3

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: The OIG did not assess VA's data for accuracy or completeness.

*****October 1, 2019, through September 30, 2020.*

†October 1, 2020, through September 30, 2021.*

‡October 1, 2021, through September 30, 2022.*

§Unique employees involved in direct medical care (cost center 8200).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 22, 2024

From: Director, VA Northwest Health Network (10N20)

Subj: Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho

To: Director, Office of Healthcare Inspections (54CH06)

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

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho.
2. I concur with the findings and recommendations and will ensure that corrective actions are completed as described in the responses.

(Original signed by:)

Teresa D. Boyd

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 20, 2024

From: Director, Boise VA Medical Center (531)

Subj: Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho

To: Director, VA Northwest Health Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho.
2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in responses to the draft report.

(Original signed by:)

David Wood
Director, Boise VA Medical Center (531)

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