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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Ann Arbor Healthcare System in Michigan

CHIP Report	22-03164-106	March 26, 2024

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Figure 1. *Lieutenant Colonel Charles S. Kettles VA Medical Center of the VA Ann Arbor Healthcare System in Michigan.*

Source: https://www.va.gov/ann-arbor-health-care/locations/ (accessed January 10, 2024.)

Abbreviations

ADPCS	Associate Director for Patient Care Services
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 VA Ann Arbor Healthcare System, which includes the Lieutenant Colonel Charles S. Kettles VA Medical Center and multiple outpatient clinics in Michigan and Ohio. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

The OIG initiated an unannounced inspection of the VA Ann Arbor Healthcare System during the week of July 24, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted an opportunity for improvement and issued one recommendation to the Chief of Staff in the Mental Health area of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered

with the delivery of quality health care. The result is detailed in the report section, and the recommendation is presented in appendix A on page 18.

VA Comments

The Veterans Integrated Service Network Director and the Medical Center Director agreed with the comprehensive healthcare inspection finding and recommendation and provided an acceptable improvement plan (see appendix C and D, pages 20–21, and the response 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 recommendation until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Ann Arbor Healthcare System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

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

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

Methodology

The VA Ann Arbor Healthcare System includes the Lieutenant Colonel Charles S. Kettles VA Medical Center and multiple outpatient clinics in Michigan and Ohio. General information about the healthcare system can be found in appendix B.

The inspection team conducted a review the week of July 24, 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 recommendation for improvement addresses a problem that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Medical Center Director's response to the report recommendation appears within the topic area. The OIG accepted the action plan that leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the VA Ann Arbor Healthcare System occurred in July 2020. The Joint Commission performed a laboratory accreditation review in June 2021 and hospital, behavioral health care, and home care accreditation reviews in September 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 healthcare system's leadership and risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

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

At the time of the OIG inspection, the executive team had worked together for approximately two months, since the appointment of the Chief of Staff. The Director, assigned in February 2018, was the most tenured member of the leadership team.

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

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $748,415,035 had increased by nearly 9 percent compared to the previous year's budget of $689,658,031.[10] The Chief of Staff reported using the increased funds to expand the workforce, including nursing and nonclinical (scheduler) positions, and to purchase high-cost, high-complexity medical equipment (magnetic resonance imaging scanners and radiation safety equipment).[11] The Director explained the importance of strategic planning to determine budget spending and using funds to fill staffing gaps. The Associate Director said the budget funded three new outpatient clinics.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[13] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The healthcare system's scores improved over all three years. The Director attributed the increased scores to the executive leadership team emphasizing the importance of open communication between leaders and staff. The Chief of Staff explained leaders focused on building trust with staff by having an open-door policy so they could communicate concerns. The ADPCS added that leaders' support for front-line staff's involvement in the healthcare system's action plans for improvement also positively affected the scores.

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

[11] Magnetic resonance imaging is a noninvasive tool used to produce detailed computer-generated images of the body using magnetic fields. "MRI [Magnetic Resonance Imaging]," Mayo Clinic, accessed January 10, 2024, https://www.mayoclinic.org/tests-procedures/mri/about/pac.

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

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

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

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
VA Ann Arbor Healthcare System	3.8	3.9	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).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

The healthcare system's inpatient satisfaction survey results indicated patients were more satisfied with the care they received than VHA patients nationally. The Chief of Staff described the assistance of medical students who spend time with patients. The Director also discussed staff responsiveness to patients and the inpatient clinical teams' bedside manner as factors contributing to the scores.

Survey scores also indicated patients' satisfaction with their primary care experiences consistently increased. The Chief of Staff attributed the improvement to a stable group of providers. The Director discussed relationships established between staff and patients, including staff learning patients' names, as contributors to positive primary care experiences.

Specialty care survey scores revealed patients were more satisfied with their care compared to VHA patients overall. The Chief of Staff attributed the positive experiences to staff assisting patients in navigating their care, including helping with transportation, lodging, and coordination of appointments to minimize trips. The Associate Director said patients were very happy with the specialty care they received but acknowledged access issues with some clinics, including optometry and ophthalmology, which had caused some dissatisfaction. The Associate Director

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

added that staff sent patients to the community for care if they could not be seen at the healthcare system within 28 days.[15]

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	80.7	69.7	82.8	68.9	79.4
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	82.6	81.9	84.7	81.7	86.7
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	88.3	83.3	85.8	83.1	86.7

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 Healthcare System Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[16] According to The Joint Commission's standards for leadership, a culture of safety and continual process

[15] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," VA, accessed January 10, 2024, https://www.va.gov/communitycare/.

[16] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," VA, accessed September 15, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

improvements lead to safe, quality care for patients.[17] 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.[18]

"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)."[19] 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."[20] 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."[21] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[22]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. The Director, Chief of Staff, and ADPCS stated staff report patient safety events through the Joint Patient Safety Reporting system.[23] The ADPCS said the Patient Safety Manager reviews the events and reports daily to the executive team during morning meetings. The Director further explained the Patient Safety Manager works with quality management staff, the ADPCS, and the Chief of Staff to

[17] 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.

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

[19] 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.

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

[21] VHA Directive 1004.08.

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

[23] VHA uses the Joint Patient Safety Reporting system to standardize and manage data on "medical errors and close calls/near misses." "VHA National Center for Patient Safety," VA, accessed September 18, 2023, https://www.patientsafety.va.gov/about/faqs.asp.

identify trends in reported events and develop solutions. The Patient Safety Manager also stated that quality management staff assign investigators to cases and track the events until they complete the investigation.

When asked about the disclosure of adverse events, the Chief of Staff and ADPCS said they coordinate with the Risk Manager to determine which events warrant institutional disclosure. The Chief of Staff described showing humility while conducting the disclosures to patients and their families.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[24] 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.[25] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[26]

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.[27] 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.[28]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[29] 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."[30] 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.[31]

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

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

[24] VA, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

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

[26] VHA Directive 1100.16.

[27] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[29] 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.

[30] VHA Directive 1190.

[31] 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 30 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.[41]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 11 patient care areas:

- Chiropractic clinic
- Dental clinic
- Emergency Department
- Medical/surgical inpatient units (5 West and 6 South)
- Medical/surgical intensive care unit (5 East)
- Mental health inpatient unit
- Orthopedic clinic
- Pain clinic
- Plastics clinic
- Podiatry clinic

[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.)

Environment of Care Findings and Recommendations

The OIG made no recommendations.

Mental Health: Suicide Prevention Initiatives

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

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.[46] 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.[47]

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.[48]

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

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

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

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

[46] 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.)

[47] 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.)

[48] 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 states that providers should complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.[49] The OIG estimated that providers did not complete the evaluation on the same day as the positive screen for 34 (95% CI: 22 to 48) percent of patients, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[50] When providers do not evaluate patients for suicidal thoughts and behaviors promptly, they may miss signs of imminent suicide risk. The Associate Chief of Mental Health for Quality stated providers complained that completing the Comprehensive Suicide Risk Evaluation was cumbersome and time consuming, and some had problems finding the evaluation template in the electronic health record.

Recommendation 1

1. The Chief of Staff ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

Healthcare system concurred.

Target date for completion: December 31, 2024

Healthcare system response: VA Ann Arbor Healthcare System regularly conducts internal monitoring of the healthcare system's adherence to Veterans Health Administration national policy and in support of the Medical Director's Senior Executive Service (SES) Performance Plan. In early FY23 the healthcare system identified retrospective findings of deficiencies in adherence to associated with ensuring providers complete the Comprehensive Suicide Risk Evaluation (CSRE) on the same day as a patient's positive suicide risk screen in all ambulatory care settings. Recognizing the role ambulatory care settings have on suicide prevention and the importance of same day suicide risk evaluations, the healthcare system's Chief of Staff and Chief of Mental Health Service developed and implemented strategies to support ambulatory clinic providers in connecting at risk Veterans with needed continued care; and to provide training and process monitoring to improve performance/compliance with CSRE policy requirements.

[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);" 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)."

[50] 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.

Implementation efforts on these improvement initiatives began in March of 2023 and consisted of 3 distinct phases.

Establishing effective pathways for providing Veterans continued required care: Chief of Staff (COS) and Chief of Mental Health Service (MHS) evaluated and re-established an effective pathway to provide Veterans continued care when a positive Columbia-Suicide Severity Rating Scale (C-SSRS) is identified. The process includes both in person and virtual "warm handoff" pathways for ambulatory care providers to transfer Veterans to dedicated mental health professionals for care.

Establishing effective method ensuring providers properly trained: Chief of Staff and Chief of Mental Health Service evaluated and established effective methodology to ensure providers in all ambulatory care settings are properly trained to complete and refer Veterans for same day Comprehensive Suicide Risk Evaluations when required. This method included establishing full time RISK ID Site Champion to provide in person training and training materials to hospital staff in all ambulatory care settings.

Establishing effective methodology for continued process monitoring: Chief of Staff established workgroup with leaders from the Chief of Staff office, Mental Health, Nursing, Ambulatory Care and RISK ID Champion to monitor progress and adherence to established policies. The workgroup meets monthly to review CSRE fall out reports and identify themes in reasons for fallouts to collectively coordinate and develop ongoing monthly training for hospital employees to improve C-SSRS and CSRE completion rates.

The healthcare system achieved significant improvements in adherence to Veterans Health Administration national policy associated with CSRE completion when comparing the January 2023 CSRE completion rate of 71% to January 2024 at 100%. However, healthcare system has been unable to sustain a completion rate above 90% for more than 3 consecutive months.

The VA Ann Arbor Healthcare System will continue implementing the strategies outlined above until it is able to achieve sustained compliance (CSRE rate of 90% or better for six consecutive months) on or before the target date of December 31, 2024.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• None
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1b) affiliated healthcare system reporting to VISN 10.[1]

Table B.1. Profile for VA Ann Arbor Healthcare System (506)
(October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$609,621,641	$689,658,031	$748,415,035
Number of:			
• Unique patients	65,860	71,573	74,994
• Outpatient visits	554,376	675,824	675,090
• Unique employees§	2,351	2,567	2,580
Type and number of operating beds:			
• Community living center	46	46	46
• Medicine	61	61	61
• Mental health	18	18	18
• Surgery	23	23	23
Average daily census:			
• Community living center	22	17	30
• Medicine	51	55	55
• Mental health	15	15	15
• Surgery	15	18	17

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

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

**October 1, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 5, 2024

From: Network Director, Veterans Integrated Service Network (10N10)

Subj: Comprehensive Healthcare Inspection of the VA Ann Arbor Healthcare System in Michigan

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

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

1. I have reviewed and concur with the response for the Comprehensive Healthcare Inspection of the VA Ann Arbor Healthcare System in Michigan.
2. I concur with the responses and action plans submitted by the Ann Arbor VA Medical Center Director.
3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Laura E. Ruzick, FACHE

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: February 28, 2024

From: Medical Center Director, VA Ann Arbor Healthcare System in Michigan (506)

Subj: Comprehensive Healthcare Inspection of the VA Ann Arbor Healthcare System in Michigan

To: Network Director, VISN 10 (10N10)

VA Ann Arbor Healthcare System is dedicated to the health and wellbeing of Veterans and ensuring adherence to Veterans Health Administration national policies.

During the first quarter of FY23, the healthcare system proactively used OIG CHIP preparation tools to identify policy adherence deficiencies associated with providers completing the Comprehensive Suicide Risk Evaluation (CSRE) in ambulatory care settings. The timely identification of these findings provided the healthcare system leadership team time to initiate coordinated efforts to streamline existing processes and procedures prior to the OIG's arrival.

The healthcare provides dedicated staffing and time, allowing Primary, Behavioral Health, and Specialty Care teams to develop and implement strategies for leveraging training and reports to properly manage care for Veterans with identified suicide ideations.

I am confident the leadership decisions made will ensure adherence to Veterans Health Administration national policy identified prior to the target date for completion.

(Original signed by:)

Ginny L. Creasman, Pharm.D., FACHE
Medical Center Director

OIG Contact and Staff Acknowledgments

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