US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin

CHIP Report | **22-03167-110** | **March 25, 2024**

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Figure 1. *William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin.*

Source: https://www.va.gov/madison-health-care/locations/william-s-middleton-memorial-veterans-hospital/ (accessed July 31, 2023).

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 William S. Middleton Memorial Veterans Hospital and multiple outpatient clinics in Illinois and Wisconsin. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

The OIG initiated an unannounced inspection of the William S. Middleton Memorial Veterans Hospital during the week of June 26, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the hospital's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted 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 hospital. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The result is detailed in the report section, and the recommendation is presented in appendix A on page 18.

VA Comments

The Veterans Integrated Service Network Director and hospital Director agreed with the comprehensive healthcare inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, pages 21–22, 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 William S. Middleton Memorial Veterans Hospital examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and hospital leaders so they can make informed decisions to improve care.[1]

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

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

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

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

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

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

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

Methodology

The William S. Middleton Memorial Veterans Hospital includes multiple outpatient clinics in Illinois and Wisconsin. General information about the hospital can be found in appendix B.

The inspection team conducted a review the week of June 26, 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 hospital leaders complete corrective actions. The Director's response to the report recommendation appears within the associated topic area. The OIG accepted the action plan 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 William S. Middleton Memorial Veterans Hospital occurred in January 2020. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in February 2021, and a laboratory accreditation review in January 2023.

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

Results and Recommendations

Leadership and Organizational Risks

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

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

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The hospital had a leadership team consisting of the Director, Chief of Staff, Associate Director 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 one month, since the appointment of the newest member, the Chief of Staff. The former Director retired in April 2023, and an Interim Director was assigned in May.[10] To help assess executive leaders' engagement, the OIG interviewed the Interim Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

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[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.

[10] The Assistant Human Resources Officer reported the director position was in the recruitment phase.

Budget and Operations

The OIG noted that the hospital's fiscal year (FY) 2022 annual medical care budget of $544,211,770 had increased by approximately 5 percent compared to the previous year's budget of $519,141,130.[11] The Associate Director reported using funds for recruitment and retention of employees including nurses, social workers, and administrative staff. The ADPCS explained that the budget supported the 72/80 staffing model, with nurses working 72 hours (six 12-hour shifts) every two weeks and being paid for 80 hours. The ADPCS added the model had improved attendance and employee satisfaction and decreased the nursing turnover rate, which allowed the hospital to remain competitive in the Madison employment market. The Chief of Staff also discussed hiring a physician recruiter to maintain recruitment success, partly through more creative use of social media. Both the Associate Director and ADPCS further reported using funds on medical equipment for areas such as the cardiovascular laboratory and operating room, as well as on safe patient handling equipment to prevent employee and patient injury.

Employee Satisfaction

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

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

All Employee Survey scores indicated employees felt more comfortable disclosing suspected violations compared to VHA employees overall. The Associate Director reported communication between managers and employees in patient safety forums positively affected the scores. The Interim Director said the hospital had a stable middle management team that established a culture in which staff were comfortable sharing concerns with their supervisors. The Interim Director added that leaders addressed problems at the hospital with a focus on processes rather than people. Quality management staff discussed a change in safety event reporting, saying that three years previously, employees reported anonymously but now they identify themselves when disclosing safety events.

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

[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
William S. Middleton Memorial Veterans Hospital	4.0	4.1	4.1

Source: VA All Employee Survey (accessed December 7, 2022).

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

Patient Experience

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

The hospital's inpatient survey scores indicated patients were more satisfied with the care they received at this hospital compared to VHA patients nationally. The Associate Director and Chief of Staff discussed staff's excellent communication with patients as a consistent factor affecting the scores. The Associate Director stated the executive leaders took pride in hospital staff, adding that a Veteran's Experience Officer met monthly with the leadership team to discuss ways to improve survey scores. The ADPCS reported conducting additional patient satisfaction surveys, and the hospital consistently compared favorably to other teaching facilities. The ADPCS also said the hospital's culture of excellence and engaged nursing staff had led to achieving the American Nurses Credentialing Center Magnet status.[15]

Survey scores also revealed patients were more satisfied with their primary and specialty care experiences compared to VHA patients overall. The Chief of Staff attributed the scores to the exceptional primary care providers, who also worked well with other providers for patients needing specialized care. The Chief of Staff added that the hospital had a great working relationship with the University of Wisconsin, which also had excellent specialists to provide

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

[15] The American Nurses Credentialing Center Magnet award "designates organizations worldwide where nursing leaders successfully align their nursing strategic goals to improve the organization's patient outcomes," "ANCC [American Nurses Credentialing Center] Magnet Recognition Program," American Nurses Association, accessed August 9, 2023, https://www.nursingworld.org/organizational-programs/magnet/.

patient care. The ADPCS discussed several nurse-driven programs at the facility as factors possibly contributing to the high scores.

The OIG observed that executive leaders and staff were very focused on patient satisfaction. The OIG learned the hospital had received the 2021 VHA Overall Best Experience Award on September 7, 2022.[16]

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Hospital	VHA	Hospital	VHA	Hospital
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	81.5	69.7	84.2	68.9	81.6
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	84.7	81.9	86.7	81.7	87.5
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	89.8	83.3	84.8	83.1	87.8

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.*

[16] "The award recognizes the breadth of customers' perceptions of their care and evaluates Veteran care interactions across their entire VA journey." "Madison VA Receives Highest National Award for Patient Experience," VA, accessed December 4, 2023, https://www.va.gov/madison-health-care/news-releases/.

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[18] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[19]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[20] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[21] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[22] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[23]

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

[18] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

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

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

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

[22] VHA Directive 1004.08.

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

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022. Patient safety staff reported six sentinel events, one institutional disclosure, and no large-scale disclosures occurred during this time frame.

The Interim Director, Chief of Staff, and ADPCS said staff report events through the Joint Patient Safety Reporting system.[24] Organizational Improvement staff discussed reviewing events daily and assigning them to the appropriate supervisors for further review; if supervisors identify an event as urgent or a sentinel event, based on The Joint Commission's definition, they immediately elevate it to the Patient Safety Manager and the executive team. Next, according to the ADPCS, patient safety staff form a team to review the event and identify any systems issues or lapses in care. Organizational Improvement staff reported the Patient Safety Manager; Chief, Organizational Improvement; and executive leaders closely collaborate throughout the sentinel event identification and reporting process. The Chief of Staff also discussed collaborating with patient safety staff and conducting institutional disclosures when needed.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[24] The Joint Patient Safety Reporting system "standardizes event capture and data management on medical errors and close calls/near misses for the Military and Veterans Health Systems." "VHA National Center for Patient Safety Frequently Asked Questions," VA, accessed December 4, 2023, https://www.patientsafety.va.gov/about/faqs.asp.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[25] 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.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[27]

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.[28] 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.[29]

The OIG assessed the hospital's processes for conducting peer reviews of clinical care.[30] 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."[31] 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.[32]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed deaths that occurred within 24 hours of inpatient admission during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

[26] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Prog*rams, July 19, 2022.

[27] VHA Directive 1100.16.

[28] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[30] 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.

[31] VHA Directive 1190.

[32] 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."[33] 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."[34]

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

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.[37]

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.[38] 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

[33] 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.)

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[39]

The OIG interviewed key managers and selected and reviewed the privileging folders of 27 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[39] 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."[40] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[41]

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.[42]

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:

- Community living centers (Hospice and Short Stay)
- Dental Clinic
- Emergency Department
- Genitourinary Clinic
- Intensive care units (8 and 8B)
- Intermediate Care Unit (4A)
- Mental Health Inpatient Unit (2B)
- Optometry Clinic
- Orthopedic Clinic

[40] 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.)

[41] 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.

[42] 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

The OIG made no recommendations.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[43] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[44] The suicide rate for veterans was higher than for nonveteran adults during 2020.[45] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[46]

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.[47] 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.[48]

VHA requires each medical facility 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.[49]

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 47 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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

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

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

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

[47] 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.)

[48] 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.)

[49] 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 calendar day as a patient's positive suicide risk screen in all ambulatory care settings.[50] The OIG estimated that providers did not complete the evaluation on the same day for 22 (95% CI: 11 to 35) percent of patients who screened positive, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[51] Failure to evaluate patients for suicidal behavior in a timely manner could result in missed opportunities for providers to identify patients at an elevated risk for suicide and intervene. The Suicide Prevention Coordinator attributed the noncompliance to communication gaps between nursing staff and providers. The Suicide Prevention Coordinator informed the OIG that to address the communication gaps, staff activated an alert in the electronic health record on January 3, 2023, to notify providers to complete the evaluation after a positive screen. Additionally, the Acting Chief of Social Work said a new provider missed several opportunities to complete the evaluation on the same day as the positive screen, but the provider subsequently received training on the correct evaluation process.

Recommendation 1

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

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

[51] 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.

Hospital concurred.

Target date for completion: October 15, 2024

Hospital response: The Chief of Staff evaluated this concern and identified no other reasons for non-compliance. William S. Middleton Memorial Veterans Hospital Suicide Prevention Team has provided multidisciplinary training regarding completion of the Comprehensive Suicide Risk Evaluation (CSRE) following a positive Columbia Suicide Severity Rating Scale (C-SSRS) across the hospital and community-based outpatient clinics. The Suicide Prevention team additionally provides training on the Suicide Risk Identification process during new PACT Provider Orientation. The Suicide Prevention team has worked with the CPRS Clinical Application Coordinators to implement a Positive C-SSRS pop up box in the electronic health record that alerts providers to the need for a same day CSRE when the screen is positive. This pop up went live on 1/3/2023 and is included in all education regarding the VA Risk Identification process. Additionally, the Suicide Prevention team reviews the Ambulatory Risk ID Fall-out dashboard each business day to identify positive C-SSRS that did not receive a CSRE. A chart review is completed for each Veteran and an email is sent to relevant providers in order to both re-educate on the process and facilitate the completion of the CSRE. Overall compliance will be monitored via the National Power BI Risk ID Dashboard: electronic Comprehensive Suicide Risk Evaluation (eCSRE) adherence rate. Suicide Prevention will submit reports to the Continuous Survey Readiness Committee until six months of 90% or greater compliance is achieved. Since October 2022, Madison VA has improved from 50% completion to 100% completion in January 2024. We have had 8 months above 90% in this time span (Jan 2023 = 100%; Feb 2023 = 100%; Mar 2023 = 92%; April 2023 = 100%; Aug 2023 = 100%; Nov 2023 = 100%; Dec 2023 = 92%; and Jan 2024 = 100%).

Report Conclusion

To assist leaders in evaluating the quality of care at their hospital, the OIG conducted a detailed inspection of five clinical and administrative areas and provided one recommendation on a systemic issue that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this hospital. However, the OIG's 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 calendar day as a patient's positive suicide risk screen in all ambulatory care settings.

Appendix B: Hospital Profile

The table below provides general background information for this high complexity (1b) affiliated hospital reporting to VISN 12.[1]

Table B.1. Profile for William S. Middleton Memorial Veterans Hospital (607) (October 1, 2019, through September 30, 2022)

Profile Element	Hospital Data FY 2020*	Hospital Data FY 2021†	Hospital Data FY 2022‡
Total medical care budget	$459,133,209	$519,141,130	$544,211,770
Number of:			
• Unique patients	40,680	41,872	43,028
• Outpatient visits	440,243	499,345	504,310
• Unique employees§	2,359	2,482	2,223
Type and number of operating beds:			
• Community living center	26	26	26
• Domiciliary	12	12	0
• Medicine	51	51	51
• Mental health	14	14	14
• Residential rehabilitation	6	6	6
• Surgery	22	22	22
Average daily census:			
• Community living center	11	–	4
• Domiciliary	5	–	–
• Medicine	52	59	58
• Mental health	7	8	9
• Residential rehabilitation	4	0	2

[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 hospital is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Hospital Data FY 2020*	Hospital Data FY 2021†	Hospital Data FY 2022‡
Average daily census, cont.:			
• Surgery	11	11	9

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 27, 2024

From: Network Director, Veterans Integrated Service Network (10N12)

Subj: Comprehensive Healthcare Inspection of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin (607)

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

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

1. I have reviewed the Comprehensive Healthcare Inspection of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin.
2. I concur with the findings and recommendations proposed.
3. I concur with the submitted action plans from the facility.
4. I would like to thank the OIG Inspection team for a thorough review of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin.

(Original signed by:)

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

Appendix D: Hospital Director Comments

Department of Veterans Affairs Memorandum

Date: February 22, 2024

From: Director, William S. Middleton Memorial Veterans Hospital (607)

Subj: Comprehensive Healthcare Inspection of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin

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

1. Thank you for the opportunity to review the draft report of the William S. Middleton Memorial Veterans Hospital inspection. I have reviewed the document and concur with the recommendations.
2. A corrective action plan has been implemented as detailed in the attached report. If additional information is needed, please contact the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin.

(Original signed by:)

Christine M. Kleckner
Director, William S. Middleton Memorial Veterans Hospital

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