US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Central Iowa Health Care System in Des Moines

CHIP Report | 23-00096-122 | April 2, 2024

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Figure 1. *Des Moines VA Medical Center of the VA Central Iowa Health Care System.*

Source: https://www.va.gov/central-iowa-health-care/locations/ (*accessed May 16, 2023*).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Central Iowa Health Care System, which includes the Des Moines VA Medical Center and multiple outpatient clinics in Iowa. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

The OIG initiated an unannounced inspection of the VA Central Iowa Health Care System 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 healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued three recommendations to the Chief of Staff in the Medical Staff Privileging 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 system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 18.

VA Comments

The Veterans Integrated Service Network Executive 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 20–21, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

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

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

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

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

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

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

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

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

Methodology

The VA Central Iowa Health Care System includes the Des Moines VA Medical Center and multiple outpatient clinics in Iowa. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review during the week of 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 recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The 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 Clinical Assessment Program review of the VA Central Iowa Health Care System occurred in December 2016. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in June 2022.

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

Results and Recommendations

Leadership and Organizational Risks

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

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

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Medical Center Director (Director); Chief of Staff; Associate Director Patient Care Services/Nurse Executive (ADPCS/NE); and Associate Director, Resources and Operations. The Chief of Staff and ADPCS/NE 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 Chief of Staff and Associate Director, Resources and Operations were assigned in May 2023. The interim Director was assigned in April 2023. The most tenured leader was the ADPCS/NE, who began in October 2016. The OIG noted that since April 2022, the

[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.

healthcare system had multiple acting, interim, and permanent staff in the director and chief of staff positions.

To help assess executive leaders' engagement, the OIG interviewed the interim Director; Chief of Staff; ADPCS/NE; and Associate Director, Resources and Operations regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted the healthcare system's fiscal year (FY) 2022 annual medical care budget of $421,397,125 had increased just over 14 percent compared to the previous year's budget of $369,335,758.[10] The interim Director and ADPCS/NE said the increased budget helped leaders fill clinical and administrative vacancies and provide recruitment and retention bonuses. The interim Director and ADPCS/NE explained they needed the salary incentives to remain competitive with local employers. The ADPCS/NE also reported using the additional funds for recurring maintenance and construction at the healthcare system.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[12] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The healthcare system's scores were similar to VHA's and stable over the three years. The ADPCS/NE described conducting separate town halls for nursing staff and requiring them to engage with leaders during their visits to workspaces. The Chief of Staff discussed planning to post instructions for reporting suspected violations clearly in all areas, including break rooms, and reinforcing the information at meetings so staff were aware of reporting options.

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

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

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

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 Central Iowa Health Care System	3.9	3.9	3.9

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.[13] 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.

Inpatient scores indicated that patients were more willing to recommend the hospital over time. Scores also revealed that patients' satisfaction with their primary care experiences declined in FY 2022 but satisfaction with their specialty care improved. The interim Director attributed the healthcare system's favorable scores to its small-town atmosphere and approachable staff.

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

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	72.3	69.7	74.5	68.9	78.4
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	88.9	81.9	90.0	81.7	88.0
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	87.8	83.3	85.7	83.1	87.4

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.[14] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[15] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[14] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

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

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

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[17] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[18] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[19] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[20]

The OIG requested a list of sentinel events and institutional disclosures that occurred during FY 2022 and reviewed the information staff provided. The ADPCS/NE and Associate Director, Resources and Operations highlighted various channels staff use to alert executive leaders to safety events, including daily meetings, calls, emails, and adverse events entered in an electronic database. Further, the executive leaders described collaborating with quality management and patient safety staff to determine follow-up actions for sentinel events.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[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.)

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[21] 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.[22] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[23]

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.[24] 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.[25]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[26] 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."[27] 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.[28]

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

Quality, Safety, and Value Findings and Recommendations

VHA requires a medical executive committee, or its equivalent, to review a "summary report from the PRC [peer review committee] discussing trends and analysis of aggregate data" on a quarterly basis.[29] The OIG reviewed Executive Committee of the Medical Staff meeting minutes and did not find evidence the committee reviewed the Peer Review Committee's quarterly

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

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

[23] VHA Directive 1100.16.

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

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

[26] 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.

[27] VHA Directive 1190.

[28] VHA Directive 1190.

[29] VHA Directive 1190.

summary.[30] This may result in the executive committee members being unaware of deficient clinical practice trends to determine the need for further action. The Risk Manager stated the Peer Review Committee verbally reported quarterly aggregate data and trends to the Executive Committee of the Medical Staff. The OIG did not make a recommendation but remains concerned that VHA does not have specific expectations for the committee documenting this review.

[30] The Executive Committee of the Medical Staff was the healthcare system's equivalent of a medical executive committee.

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."[31] 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."[32]

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

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation (OPPE) to ensure the continuous delivery of quality care.[35]

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.[36] 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

[31] 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.)

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[37]

The OIG interviewed key managers and selected and reviewed the privileging folders of 26 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires providers with equivalent specialized training and similar privileges to complete LIPs' OPPEs.[38] The OIG found that similarly trained and privileged providers did not consistently complete LIPs' OPPEs (including those for solo providers), jeopardizing patient safety if specific practice deficiencies are unidentified.[39] The Chief of Staff reported sending OPPEs for the solo LIPs to the VISN, believing VISN staff would assign a similarly privileged provider from another facility to complete them, and being unable to provide a reason for noncompliance for the other, non-solo LIPs.

Recommendation 1

1. The Chief of Staff ensures providers with equivalent specialized training and similar privileges complete licensed independent practitioners' Ongoing Professional Practice Evaluations.

[37] Assistant Under Secretary for Health Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

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

[39] VHA refers to a solo practitioner as being the only provider at the facility who is privileged in a particular specialty. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators."

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) visit June 26-29, 2023, found the Chief of Staff (COS) had not ensured providers with equivalent specialized training and similar privileges had completed Licensed Independent Practitioners' (LIPs') Ongoing Professional Practice Evaluations (OPPEs). The Chief of Staff will ensure that OPPEs that are sent out are completed by a similarly trained provider with similar privileges. If a Focused Professional Practice (FPPE)/OPPE is sent out of the facility for review, the Credentialing and Privileging Manager will request the reviewing provider's privileges be attached upon return, thus assuring that a provider with similar privileges has reviewed the FPPE/OPPE.

The Credentialing and Privileging Manager will monitor all OPPEs monthly to ensure there is 90% or greater compliance with equivalent, similarly trained providers who are completing OPPEs for the LIPs. Monitoring for six months of continuous compliance of 90% or greater will be reported and recorded monthly in the meeting minutes of the Quality and Patient Safety Council (QPSC) beginning in the April 2024 meeting.

VHA requires service chiefs to recommend reprivileging based, in part, on OPPE activities such as direct observation, chart reviews, and clinical discussions.[40] The OIG found that some LIPs' OPPEs lacked evidence service chiefs recommended continued privileges based on OPPE activities. This may have resulted in LIPs not receiving thorough practice evaluations, which could negatively affect patient safety. The Chief of Staff cited service chiefs' lack of training and awareness of the requirement due to turnover in the positions.

Recommendation 2

2. The Chief of Staff ensures service chiefs recommend continued privileges for licensed independent practitioners based, in part, on Ongoing Professional Practice Evaluation activities.

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

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: During the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) visit June 26-29, 2023, it was found that some licensed independent practitioners (LIPs') Ongoing Professional Practice Evaluations (OPPEs) lacked evidence service chiefs recommended to continue privileges based on OPPE assessments.

The Chief of Staff (COS) office will ensure training is provided to all service chiefs in relation to this requirement, COS office will also ensure update to the OPPE forms to allow the service chiefs to document recommendations for or against continued LIP privileges based in part on the outcome of OPPE assessments. The COS office will also ensure all OPPEs are reported at the Executive Committee of Medical Staff (ECOMS) and are accurately documented in the meeting minutes.

The COS office will complete monthly monitoring to ensure that all OPPEs are signed by service chiefs recommending for or against continued privileges based on the OPPE process. The monitoring will continue for six months of continuous compliance 90% or greater and will be reported and recorded in the Quality and Patient Safety Council (QPSC) meeting minutes beginning April 2024.

VHA requires the Focused Professional Practice Evaluation process to "be defined in advance, using objective criteria accepted by the LIP."[41] The OIG did not find evidence LIPs accepted the evaluation criteria prior to service chiefs initiating the process. When LIPs are not aware of the criteria used to evaluate their performance, they may not understand evaluation expectations. The Chief of Staff said the process had been for service chiefs to sign evaluation criteria statements when completing LIPs' credentialing, then the LIPs sign the statements prior to initial privileging. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

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

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

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.[44]

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

- Community living center (CLC 2)
- Emergency Department
- Intensive Care Unit
- Medical/surgical inpatient unit (3B)
- Mental health inpatient unit (3A acute)
- Specialty clinic (2A)

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[42] 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.)

[43] 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.

[44] 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.)

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

[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 January 20, 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 states providers should complete the Comprehensive Suicide Risk Evaluation on the same day as a positive suicide risk screen in ambulatory care settings.[52] The OIG found that providers did not complete the evaluation on the same day as the positive screen for 17 percent of patients. Failure to evaluate patients promptly could result in missed opportunities for providers to identify patients at imminent risk for suicide and intervene. The Associate Chief of Staff, Primary Care and the Suicide Prevention Coordinator identified a lack of provider education and competing clinical duties as factors contributing to delays in completing evaluations.

Recommendation 3

3. 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 ambulatory care settings.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: During the Office of Inspector General (OIG) Comprehensive Healthcare Inspection (CHIP) visit June 26-29, 2024, it was recognized that 17% of patient records reviewed in ambulatory care settings with a positive Columbia Suicide Rating Scale (C-SSRS) did not have a Comprehensive Suicide Risk Evaluation (CSRE) completed within the appropriate timeframe.

Education was provided to all members of the Organized Medical Staff (OMS), to include the licensed independent practitioners (LIPs), at the February 22, 2024, OMS meeting and recorded in minutes. Notification will be sent out no later than March 15, 2024, to all clinical staff, to include but not limited to LIPs regarding their role and the expectations to complete the comprehensive assessment (CSRE) when the Suicide Screening (C-SSRS) is positive.

The Suicide Prevention Coordinator will monitor patients in the ambulatory care setting, with a positive suicide screening (C-SSRS) have had a comprehensive assessment (CSRE) completed. Compliance with this monitoring will be reported and recorded in the meeting minutes of the Quality and Patient Safety Council (QPSC). Monitoring will continue for six months with continuous compliance 90% or greater beginning April 2024.

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

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are 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	• Providers with equivalent specialized training and similar privileges complete licensed independent practitioners' Ongoing Professional Practice Evaluations. • Service chiefs recommend continued privileges for licensed independent practitioners based, in part, on Ongoing Professional Practice Evaluation activities.
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 ambulatory care settings.

Appendix B: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated healthcare system reporting to VISN 23.[1]

Table B.1. Profile for VA Central Iowa Health Care System (636A6) (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	$327,973,579	$369,335,758	$421,397,125
Number of:			
• Unique patients	31,215	32,442	32,715
• Outpatient visits	347,683	403,444	401,055
• Unique employees§	1,245	1,249	1,257
Type and number of operating beds:			
• Community living center	108	108	56
• Domiciliary	60	48	48
• Medicine	55	55	45
Average daily census:			
• Community living center	86	64	48
• Domiciliary	24	20	23
• Medicine	30	32	36

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 "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 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 7, 2024

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

Subj: Comprehensive Healthcare Inspection of the VA Central Iowa Health Care System in Des Moines

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

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection draft report of the Central Iowa VA Health Care System. I concur with the recommendations outlined in this report.
2. Central Iowa VA Health Care System has submitted the action plans and monitors to demonstrate compliance with the recommendations.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts.

(Original signed by:)

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

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 4, 2024

From: Director, VA Central Iowa Health Care System (636A6)

Subj: Comprehensive Healthcare Inspection of the VA Central Iowa Health Care System in Des Moines

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

Thank you for the opportunity to review and comment on the draft report for the Comprehensive Healthcare Inspection of the VA Central Iowa Health Care System in Des Moines, Iowa.

I concur with the recommendations outlined in this report and am submitting the corrective actions taken to improve our processes.

I appreciate the review by the OIG as part of our ongoing commitment to process improvement to ensure safe and quality care to Veterans.

(Original signed by:)

Lisa R. Curnes
Medical Center Director

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