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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin

CHIP Report | **22-04132-48** | **January 10, 2024**

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Figure 1. *Tomah VA Medical Center in Wisconsin.*
Source: https://www.va.gov/tomah-health-care (accessed January 3, 2023).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
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 Tomah VA Medical Center and multiple outpatient clinics in 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 Tomah VA Medical Center during the week of December 12, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued five recommendations to the Medical Center Director and Chief of Staff in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the

delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 21.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 23–24, 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 Tomah VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so they can make informed decisions to improve care.[1]

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

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

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

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[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 Tomah VA Medical Center also provides care through multiple outpatient clinics in Wisconsin. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review beginning the week of December 12, 2022.[5] Following the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline for further review.

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until medical center leaders complete corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the Tomah VA Medical Center occurred in January 2020. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in April 2021.

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

Results and Recommendations

Leadership and Organizational Risks

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

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

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate 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 about two months. The Director and ADPCS were permanently assigned in February and June 2021, respectively. The Chief of Staff started in October 2022, and the acting Associate Director had served for about seven months, although the position had not been permanently occupied since August 2021.

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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.

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

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $370,488,555 had increased by over 12 percent compared to the previous year's budget of $329,567,941.[10] The Director reported that the budget was adequate, and leaders used funds to recruit, retain, and relocate new employees. The Director further shared that the budget allowed leaders to relocate two community-based outpatient clinics to new buildings in La Crosse and Wausau, Wisconsin, and purchase high-dollar medications. The acting Associate Director added that pharmacy costs were high due to mail-ordered prescriptions, which accounted for approximately 85 percent of prescriptions filled at the facility. The acting Associate Director also described how medication recalls contributed to an increase in pharmacy expenses as staff purchased more expensive alternative medications as substitutions.

The Director also reported spending $120 million on care in the community and discussed strategies to decrease community care expenses, such as offering radiology services and opening a pulmonary clinic at the main facility.[11] The Director further described providing podiatry and dental care at community-based outpatient clinics and partnering with the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin, for other specialties not offered at the medical center.

The Director and acting Associate Director reported an FY 2022 budget surplus of around $3 million. The Director said the facility carried over the funds to be used toward the FY 2023 operating budget. The acting Associate Director stated some of the money left from FY 2022 was related to full-time employee vacancies that remained unfilled.

The Director reported that, despite challenges with the medical center's human resources modernization efforts, leaders had a collaborative relationship with the VISN Human Resource Modernization Lead.[12] In addition, the Director partly attributed recruitment and hiring problems to the facility's rural location and lack of human resources staff. As an example of the effect of recruitment challenges, the Director shared that the Mental Health Residential Rehabilitation

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

[11] VA pays for care by community providers in certain circumstances. "Community Care: Veteran Care Overview," Department of Veterans Affairs, accessed May 16, 2023, https://www.va.gov/COMMUNITYCARE/programs/veterans/index.asp.

[12] VHA facilities' human resources offices operated independently, with most procedures specific to the individual facility, until October 2018, when facility offices were consolidated under their VISN, with shared services and procedures. "VHA Modernization: Develop Responsive Shared Services," VA Insider, accessed February 10, 2023, https://vaww.insider.va.gov/vha-modernization-develop-responsive-shared-services/. (This website is not publicly accessible.)

Treatment program was authorized 70 patient beds, but due to difficulty recruiting clinical social workers and psychologists, the number of beds for use was decreased to 26.[13]

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[14] 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 center 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.[15] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The medical center's scores were similar to VHA averages for all three years. The Director said the medical center had the highest number of reported patient safety events among similar facilities in the VISN and reported believing this demonstrated a culture in which staff felt comfortable disclosing safety concerns. The Director also described participating in facility walk-arounds and new employee orientations. In general, the leaders emphasized focusing on improving the process and not blaming the employees. The Chief of Staff discussed leaders' initiatives to engage staff such as sharing accrediting and oversight agency reports with employees for transparency, hiring an equal employment coordinator, and encouraging employees to work with the union.

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
Tomah VA Medical Center	3.8	3.8	3.8

Source: VA All Employee Survey (accessed October 13, 2022).

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

[13] The Residential Rehabilitation Treatment program provides services to veterans with "mental health and substance use disorders" that often "co-occur with medical concerns and psychosocial needs." VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019.

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

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

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.[16] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from October 2019 (FY 2020) to July 2022 (FY 2022). Table 2 provides survey results for VHA and the medical center over time.[17]

Patients' satisfaction with their inpatient experiences declined in FY 2021 but increased significantly in FY 2022. The Director said efforts to improve inpatient satisfaction included the unit managers walking around all inpatient areas daily. The Chief of Staff and ADPCS reported that staff could improve how they educated patients about their medications during discharge from the medical center, so leaders assigned a pharmacist to assist with this process. The ADPCS also said leaders bought white noise speakers for inpatient rooms to provide patients with comforting sounds and facilitate sleep.

Patients' satisfaction with their primary and specialty care experiences also declined in FY 2021 but increased significantly in FY 2022. The ADPCS attributed the increased primary care satisfaction to the integration of the Whole Health initiative in primary and mental health care clinics.[18]

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

[17] Scores are based on responses by patients who received care at this medical center.

[18] "Whole Health is VA's approach to care that supports your [the patient's] health and well-being," focusing on developing "a personalized health plan based on your [the patient's] values, needs, and goals." VHA, "Whole Health," accessed May 16, 2023, https://www.va.gov/wholehealth/.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	79.1	69.7	69.1	68.5	80.0
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?* †	82.5	88.1	81.9	85.2	81.0	90.3
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	88.6	83.3	83.6	82.0	95.4

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 7, 2022).

**The response average is the percent of "Definitely yes" responses.*

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[19] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[20] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

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[19] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 7, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[20] 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, accessed September 23, 2021, 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.[21]

"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)."[22] 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."[23] 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."[24] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[25]

The OIG requested a list of adverse patient safety events that occurred from October 1, 2021, through September 30, 2022, and reviewed the information quality management staff provided. The Director said quality management staff provided a comprehensive report of patient safety events and previous findings from The Joint Commission and the OIG to the Leadership Quality Council, which is composed of executive leaders, quality management staff, and representatives from various committees. The executive leaders explained that staff enter patient safety events into the Joint Patient Safety Reporting system and leaders discuss the events with quality management staff to determine whether they should be classified as sentinel events.[26] The Chief of Staff described meeting with the ADPCS and the Patient Safety Manager or Chief of Quality Management to determine whether sentinel events meet disclosure criteria, such as resulting in patients' serious injury or death. The ADPCS reported participating in the disclosure process by addressing nursing-related questions when needed.

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

[22] 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.

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

[24] VHA Directive 1004.08.

[25] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded this handbook and replaced it 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).

[26] VHA uses the Joint Patient Safety Report System for data management of patient safety events such as "medical errors and close calls/near misses." "Frequently Asked Questions," VHA National Center for Patient Safety, accessed December 21, 2022, https://www.patientsafety.va.gov/about/faqs.asp.

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.[27] 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.[28] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[29]

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.[30] 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.[31]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[32] 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."[33] 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.[34]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[29] VHA Directive 1100.16.

[30] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[32] 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.

[33] VHA Directive 1190.

[34] 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."[35] 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."[36]

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

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE 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.[39]

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.[40] 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

[35] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded this handbook and replaced it 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.)

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position job descriptions.[41]

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

VHA requires service chiefs to conduct Ongoing Professional Practice Evaluations to monitor LIPs' performance on a regular basis.[42] The OIG found that service chiefs did not consistently conduct Ongoing Professional Practice Evaluations for LIPs, including for solo or few practitioners.[43] The lack of a thorough competency evaluation could adversely affect quality of care and patient safety. The Chief of Staff and the Credentialing and Privileging Manager attributed the noncompliance to a credentialing and privileging analyst's mismanagement and misplacement of Ongoing Professional Practice Evaluation documents and privileging folders. Additionally, the Chief of Staff indicated that facility leaders, despite their attempts, were unable to obtain assistance from LIPs at other facilities within the VISN to evaluate the solo or few practitioners.

Recommendation 1

1. The Chief of Staff ensures service chiefs monitor licensed independent practitioners' performance by conducting Ongoing Professional Practice Evaluations on a regular basis.

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

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

[43] VHA refers to a solo practitioner as being one provider in 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," May 18, 2021. The OIG considers few practitioners as being two providers in the facility who are privileged in a particular specialty.

Medical center concurred.

Target date for completion: June 1, 2024

Medical center response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The medical center service chiefs will coordinate with the Ongoing Professional Practice Evaluation reviewer to ensure compliance. The credentialing and privileging staff will track and monitor Ongoing Professional Practice Evaluations every month. The numerator equals the number of providers undergoing privileging review with current Ongoing Professional Practice Evaluations on file. The denominator equals the total number of providers undergoing privileging review. The Credentialing and Privileging Manager will report the compliance results monthly to the Professional Standards Board chaired by the Chief of Staff until 90 percent compliance is achieved and sustained for six consecutive months.

VHA requires the chief of staff to ensure FPPE criteria are "defined in advance, using objective criteria accepted by the LIP."[44] The OIG found that all three FPPEs reviewed lacked evidence the LIPs accepted the evaluation criteria before the service chiefs initiated the process. When service chiefs do not communicate evaluation criteria, LIPs could misunderstand FPPE expectations. The Chief of Staff stated that service chiefs reviewed FPPE criteria during the LIPs' orientation and onboarding but did not document they received and accepted it. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

[44] 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."[45] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[46]

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.[47]

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:

- Acute Inpatient Mental Health Unit
- Acute medical inpatient unit
- Community living center (Small Homes)
- Primary care clinic (Blue)
- Urgent care clinic
- Women's health clinic

Environment of Care Findings and Recommendations

VHA requires each facility to have a comprehensive environment of care program, which includes staff conducting environment of care inspections at "a minimum of once per fiscal year

[45] 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.)

[46] 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.

[47] 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, *Standards for Community Living Centers*, October 5, 2023.)

in non-patient care areas, and twice per fiscal year in all areas where patient care is delivered," and documenting completion of each inspection.[48] Additionally, VHA requires a comprehensive environment of care rounds coordinator (the Safety and Occupational Health Specialist at this medical center) to schedule inspection rounds and maintain the records.[49] The OIG noted that staff did not consistently inspect patient and non-patient care areas. This may have resulted in staff's inability to proactively identify unsafe conditions in these areas. The Safety and Occupational Health Specialist reported that staff inspected the areas but did not document it because they accidentally omitted these areas from the inspection form.

Recommendation 2

2. The Medical Center Director ensures the Safety and Occupational Health Specialist or designee schedules and ensures staff complete and document environment of care inspections at the required frequency.

Medical center concurred.

Target date for completion: July 31, 2024

Medical center response: The Medical Center Director will ensure that facility staff complete and document the number of environmental care rounds required for each area. Health occupancy buildings will have the minimum required inspections each fiscal year. The Safety Chief will be responsible for tracking and monitoring the number of environmental care rounds completed each month using an electronic data base. The numerator equals the number of environment of care rounds completed each month. The denominator is the total number of environment of care inspections expected to be competed each month. The Safety Chief will report the compliance rate monthly to the Environment of Care Committee, which is chaired by the Associate Director until 90 percent compliance is achieved and sustained for six consecutive months.

At facilities with inpatient mental health units, VHA requires staff to perform systematic environmental assessments using the Mental Health Environment of Care Checklist to identify and address environmental risks for patients under treatment.[50] The Mental Health Environment of Care Checklist criteria state that staff test panic alarms at least quarterly and document testing and VA police response times in a log.[51]

The OIG reviewed the facility's log for panic alarm testing that occurred from July 1, 2022, through September 30, 2022, and did not find evidence staff monitored VA police response

[48] VHA Directive 1608.

[49] VHA Directive 1608.

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

[51] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," October 18, 2022.

times. Failure to monitor police response times to panic alarm testing may put patients, visitors, and staff at risk in the event of an actual emergency. The Associate Chief of Staff, Mental Health and Police Captain reported being unaware of the requirement.

Recommendation 3

3. The Medical Center Director ensures staff monitor and document VA police response times to panic alarm testing in the Acute Inpatient Mental Health Unit at least quarterly.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The Medical Center Director will ensure that facility staff monitor and document VA police response time to the quarterly panic alarm testing in the Acute Inpatient Mental Health Unit. The Nurse Manager, RN-Mental Health will be responsible for the tracking and monitoring of the quarterly panic alarm testing. The numerator equals the number of panic alarms tested with documented police response times each quarter. The denominator equals the total number of panic alarms tested each quarter. The Nurse Manager, RN-Mental Health will report the compliance rate quarterly to the Leadership Quality Council until 90 percent compliance is achieved and sustained for two quarters.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[52] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[53] The suicide rate for veterans was higher than for nonveteran adults during 2020.[54] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[55]

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.[56] 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.[57]

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.[58]

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

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

[53] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 16, 2023, https://www.cdc.gov/suicide/facts/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fsuicide%2Ffastfact.html.

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

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

[56] 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.)

[57] 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.)

[58] 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.)

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

Mental Health Findings and Recommendations

VHA requires the suicide prevention coordinator to perform at least five activities a month involving outreach to veterans and their families, in coordination with community organizations, to improve suicide prevention and care coordination.[59] The OIG reviewed outreach reports for the last six months of FY 2022 and found the Suicide Prevention Coordinator did not conduct two outreach activities in May and three in June. This resulted in missed opportunities for the coordinator to build relationships with community organizations and stakeholders to enhance suicide prevention initiatives. The Suicide Prevention Coordinator Lead attributed the noncompliance to focusing on the patient flag process and responding to crisis calls.[60]

Recommendation 4

4. The Medical Center Director ensures the Suicide Prevention Coordinator conducts a minimum of five outreach activities each month.

Medical center concurred.

Target date for completion: June 30, 2024

Medical center response: The Medical Center Director will ensure that the Suicide Prevention Team conducts the required number of outreach activities each month. The Suicide Prevention Program Manager will be responsible for tracking and monitoring outreach activities each month. The numerator equals the total number of outreach activities conducted each month. The denominator equals the total number of required outreach activities to be completed each month. The Suicide Prevention Program Manager will report the compliance rate bimonthly to the Leadership Quality Council until 90 percent compliance is achieved and sustained for six consecutive months.

VHA also requires the suicide prevention coordinator to report suicide-related events monthly to "local mental health leadership and quality management."[61] The OIG found the Suicide Prevention Coordinator did not report suicide-related events monthly to mental health and quality management leaders. When the Suicide Prevention Coordinator does not report suicide-related events, leaders may miss opportunities to analyze data and improve suicide prevention

[59] VHA Directive 1160.07.

[60] The Patient Record Flag is used within the electronic health record system to "identify patients with a clear risk to safety." Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," updated December 2022.

[61] VHA Directive 1160.07.

processes. The Suicide Prevention Coordinator Lead reported providing suicide-related information the day a suicide occurred only to the Associate Chief of Staff, Mental Health.

Recommendation 5

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

Medical center concurred.

Target date for completion: June 30, 2024

Medical center response: The Medical Center Director will ensure that the Suicide Prevention Team reports suicide related events to mental health leadership and quality management monthly. The Suicide Prevention Program Manager will be responsible for tracking and monitoring monthly suicide related events. The numerator equals the total number of suicide related events reported to mental health leadership and quality management each month. The denominator equals the total number of suicide related events that occurred each month. The Suicide Prevention Program Manager will report the compliance rate bimonthly to the Leadership Quality Council until 90 percent compliance is achieved and sustained for six consecutive months.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs monitor licensed independent practitioners' performance by conducting Ongoing Professional Practice Evaluations on a regular basis.
Environment of Care	• The Safety and Occupational Health Specialist or designee schedules and ensures staff complete and document environment of care inspections at the required frequency. • Staff monitor and document VA police response times to panic alarm testing in the Acute Inpatient Mental Health Unit at least quarterly.
Mental Health: Suicide Prevention Initiatives	• The Suicide Prevention Coordinator conducts a minimum of five outreach activities each month. • The Suicide Prevention Coordinator reports suicide-related events monthly to mental health and quality management leaders.

Appendix B: Medical Center Profile

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

Table B.1. Profile for Tomah VA Medical Center (676)
(October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$260,090,017	$329,567,941	$370,488,555
Number of: • Unique patients	25,489	25,971	27,255
• Outpatient visits	259,208	294,584	258,224
• Unique employees§	1,075	1,109	1,109
Type and number of operating beds: • Community living center	180	180	180
• Domiciliary	80	80	36
• Medicine	10	10	9
• Mental health	11	11	11
• Residential rehabilitation	10	10	10
Average daily census: • Community living center	123	99	97
• Domiciliary	31	27	26
• Medicine	3	3	3
• Mental health	4	4	3
• Residential rehabilitation	5	2	6

Source: VHA Support Service Center and VA Corporate Data Warehouse.
Note: The OIG did not assess VA's data for accuracy or completeness.
**October 1, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

[1] VHA medical facilities are classified according to a complexity model; a designation of "3" indicates a facility with "low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated 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: December 8, 2023

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

Subj: Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin

To: Director, Office of Healthcare Inspections (54CH06)
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL)

1. I have reviewed the Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin, draft report.
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 Tomah VA Medical Center in Wisconsin.

(Original signed by:)

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

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: December 8, 2023

From: Director, Tomah VA Medical Center (676)

Subj: Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin

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

1. Thank you for the opportunity to review the draft report of the Tomah VA Medical Center 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 Tomah VA Medical Center.

(Original signed by:)

Karen Long, MSN, RN
Medical Center Director

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