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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Battle Creek VA Medical Center in Michigan

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Figure 1. *Battle Creek VA Medical Center in Michigan.*
Source: https://www.va.gov/battle-creek-health-care/locations/ (accessed February 15, 2023).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
COS	Chief of Staff
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 Battle Creek VA Medical Center, which includes outpatient clinics located in Michigan. 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 Battle Creek VA Medical Center during the week of February 27, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted an opportunity for improvement and issued one recommendation to the Chief of Staff in the Mental Health review area. 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 result is detailed in the report section, and the recommendation is presented in appendix A on page 18.

VA Comments

The Veterans Integrated Service Network Director and Executive Medical Center Director agreed with the comprehensive healthcare inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, pages 21–22, and the response within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendation until they are completed.

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Purpose and Scope

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

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

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

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

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

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

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

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

Methodology

The Battle Creek VA Medical Center includes multiple outpatient clinics in Michigan. General information about the types of care provided by the medical center can be found in appendix B.

The OIG inspected the Battle Creek VA Medical Center during the week of February 27, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendation for improvement addresses a problem that can influence the quality of patient care significantly enough to warrant OIG follow-up until medical center leaders complete corrective actions. The Medical Center Director's response to the report recommendation appears within the associated topic area. The OIG accepted the action plan that leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the Battle Creek VA Medical Center occurred in July 2020. The Joint Commission performed hospital, behavioral health care, home care, and laboratory accreditation reviews in August and September 2021.

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

Results and Recommendations

Leadership and Organizational Risks

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

To assess this 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 (COS), Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. The COS 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 over one year. The COS, who was appointed in 2013, was the most tenured executive team member. To help assess the executive leaders' engagement, the OIG interviewed the Director, COS, ADPCS, Associate Director, and Assistant Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

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

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

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

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $496,958,869 had increased by almost 11 percent compared to the previous year's budget of $449,388,433.[10] The COS reported using some of the funds to improve the 100-year-old facility, including renovating the community living center and mental health clinic.

The Director and Associate Director both discussed using the funds to hire staff to support the new Oracle Cerner electronic health record deployment.[11] The Assistant Director identified a $36 million deficit in the medical center's budget due to these supplemental staff salaries and the projected need for approximately 250 more clinical, administrative, and information technology positions to address Oracle Cerner system issues. The Assistant Director also described challenges with hiring and meeting baseline staffing levels due to the medical center's geographic location.

Oracle Cerner Electronic Health Record Implementation

The OIG team interviewed the Assistant Director, who oversaw the Oracle Cerner transition as the Electronic Health Record Modernization Deployment Lead, and the Associate Director, who was involved with the go-live process. Both leaders expressed concerns with Oracle Cerner implementation, provided information on the medical center's preparation for going live, and stressed that patient safety was the leadership team's priority.

The Associate Director described challenges receiving comprehensible implementation guidance from the Oracle Cerner team. The Assistant Director also stated that leaders expected guidance from VA's Office of Electronic Health Record Modernization about risk identification and mitigation for the Oracle Cerner system to ensure veterans were protected. The Associate Director explained Oracle Cerner expected a medical center employee working in the new electronic health record system to report concerns, but the employee might not recognize a concern as a patient safety issue or understand the possible ripple effect a problem could have on patient safety.[12] The Associate Director stated leaders were proactively setting up an incident command system for go-live, separate from Oracle Cerner's, to ensure the leadership team's awareness of patient safety issues, which would allow staff to express any patient safety

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

[11] VA's Electronic Health Record Modernization program deployment is the effort to transition to a new commercial electronic health system, Oracle Cerner, developed by Cerner Corporation. "VA EHR Modernization," Department of Veterans Affairs, accessed August 30, 2023, https://digital.va.gov/ehr-modernization/resources/frequently-asked-question/.

[12] Following go-live, facility staff would use a ticket system to request assistance or report issues that needed corrective action with the Oracle Cerner electronic health record. VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-108, March 17, 2022.

concerns directly to leaders for proactive risk assessment and mitigation. According to the Associate Director, if an adverse patient event happened, the executive leaders would appear on the news responding to questions because the team is responsible for ensuring safe, quality care for veterans in the area.

At the time of the OIG review, the Associate Director and Assistant Director stated the medical center's scheduled Oracle Cerner go-live date was July 22, 2023. On April 21, 2023, the VA Under Secretary for Health released an announcement that VA was halting all future deployments of the new electronic health record and prioritizing a reset with the five sites that currently use it.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] 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.[14] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The OIG noted that the medical center's scores had increased each year. To continue improving employee satisfaction, the Director reported looking for ways to engage front-line staff, including forming an employee engagement committee and designating a day for leaders and staff to discuss using data to improve patient care. The Director also mentioned implementing a virtual suggestion box in which staff shared clinical and nonclinical ideas that leaders responded to in town hall meetings. The Associate Director attributed the increased scores to the Director's leadership style and to leading by example, which builds staff trust and results in culture change.

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

[14] 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
Battle Creek VA Medical Center	3.7	3.8	3.9

Source: VA All Employee Survey (accessed November 8, 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.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

The medical center's inpatient satisfaction survey scores indicated patients were less likely to recommend the hospital to friends and family compared to VHA patients nationally in FYs 2020 and 2021. The Director attributed the scores to the medical center's small acute care inpatient unit having no subspecialty support and explained the medical center relied on community partners to care for inpatients with complex needs. Further, the Director reported that to use resources more wisely, leaders had decided to reduce the number of inpatient beds and requested permanent closure of the acute care inpatient unit from the VA Under Secretary for Health.[16]

The medical center's primary care satisfaction survey scores increased over all three years. The COS explained leaders employed multiple communication techniques to increase patient satisfaction, such as staff promptly returning patient phone calls and using an interdisciplinary approach to patient care. The ADPCS discussed soliciting immediate feedback from patients to gain knowledge about their experiences, including using a canister in which patients drop a red

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

[16] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Clinical Restructuring Request (CRR) for Permanent Closure of the Acute Medical Unit at Battle Creek Veterans Affairs Medical Center (VAMC), Battle Creek, Michigan," December 2, 2022. The VA Under Secretary for Health approved the permanent closure of the medical center's acute care inpatient unit on March 9, 2023.

ball (for a negative experience) or green ball (for a positive experience), to inform improvements.

Outpatient specialty care survey results appeared to indicate patients were generally satisfied with their care. The COS explained that leaders had worked to ensure patients were satisfied with their specialty care, especially at clinics with lower scores like podiatry and audiology. The ADPCS added the medical center employed staff who work as navigators to assist patients through the specialty care process, stating that care coordination and integrated case management benefited the most vulnerable patients.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	64.0	69.7	55.1	68.9	75.8
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	80.3	81.9	81.1	81.7	83.1
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	84.4	83.3	86.2	83.1	87.9

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

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

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

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

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

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

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

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

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

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

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

[22] VHA Directive 1004.08.

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

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. The Director, COS, and ADPCS indicated staff report adverse events through the Joint Patient Safety Reporting system.[24] The Director stated patient safety managers discuss events during daily huddles and assign each incident to appropriate employees to determine the need for further action such as a disclosure, peer review, or root cause analysis.[25] Quality management staff also explained they reference VHA guidance and consult with VISN partners when needed to determine whether to identify an event as a sentinel event. The COS discussed coordinating with patient safety managers, the Risk Manager, and the Peer Review Committee to determine whether events warrant institutional disclosures and completing the disclosures when required.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[24] The Joint Patient Safety Reporting system is used to "standardize event capture and data management on medical errors and close calls/near misses." "VHA National Center for Patient Safety Frequently Asked Questions," Department of Veterans Affairs, accessed January 8, 2024, https://www.patientsafety.va.gov/about/faqs.asp.

[25] 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. A root cause analysis "is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[26] 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.[27] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[28]

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.[29] 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.[30]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care. Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[31] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[32]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed information for one death that occurred within 24 hours of inpatient admission and two suicides that occurred within seven days of discharge from an inpatient mental health unit during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

[26] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[27] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.
[28] VHA Directive 1100.16.
[29] VHA Handbook 1050.01; VHA Directive 1050.01.
[30] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.
[31] VHA Directive 1190.
[32] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[33] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[34]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[35] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[36]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[37]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[38] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the COS. VHA also requires each facility to have credentialing and privileging managers and specialists with job duties that align under standard position descriptions.[39]

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[33] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Directive 1100.20.

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

The OIG interviewed key managers and selected and reviewed the privileging folders of 29 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

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 the environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[40] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[41]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[42]

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

- Community living center (Light House)
- Infusion Clinic
- Inpatient mental health unit (39-West)
- Urgent Care Center
- Women's Health Clinic

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[40] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[41] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[42] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

Mental Health: Suicide Prevention Initiatives

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

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[47] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[48]

VHA requires each medical 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.[49]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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

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

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

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

[47] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[48] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[49] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

VHA requires providers to complete the Comprehensive Suicide Risk Evaluation for patients following a positive suicide risk screen.[50] The OIG found that providers did not complete the evaluation following a positive suicide risk screen for 64 (95% CI: 50 to 76) percent of patients, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[51] Failure to evaluate patients for suicidal behavior could result in missed opportunities for providers to identify patients who are at an elevated risk for suicide and intervene. The COS explained that only mental health providers completed the Comprehensive Suicide Risk Evaluation at the medical center because primary care providers said they did not have enough time to complete the evaluations carefully and thoughtfully.

Recommendation 1

1. The Chief of Staff ensures providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.

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

[51] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Medical center concurred.

Target date for completion: June 1, 2024

Medical center response: The following action plan was developed and implemented to improve provider compliance with the completion of the Comprehensive Suicide Risk Evaluation (CSRE) following a patient's positive suicide risk screen.

1. Two Warm Handoff Guidelines were developed for the Comprehensive Suicide Risk Evaluation and provided to Ambulatory Care and Patient Aligned Care Teams (PACT).
2. A Standard Operating Procedure, Guidelines for Warm Hand Off Following a Positive Suicide Screen Clinical Reminder in Primary Care was developed and published.
3. Weekly VA Suicide Risk Identification Strategy (Risk ID) meetings occur with RISK ID Champions.
4. Monthly Universal Risk ID Workgroup meets to discuss high and low performing areas. Discussion includes how to conduct a proper warm handoff and to determine if individual areas need additional education.
5. Suicide Prevention Team reviews a 2:30 p.m. report that is generated in the Computerized Patient Record System (CPRS) to monitor for positive Columbia-Suicide Severity Rating Scale (CSSRS) that were completed without a CSRE documented. Follow up is provided if necessary.
6. Suicide Prevention Team reviews daily dashboards that identify any missed CSRE opportunities from the day prior or during weekend, holiday, evening, and night hours.
7. One All PACT Risk ID Training was conducted. An additional training is scheduled February 2024.
8. Eleven department specific trainings were conducted.
9. A Risk ID refresher training was provided for all Program Managers September 2023. Additional Risk ID refresher training will be scheduled.

The action plan will be monitored until 90 percent compliance is maintained 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 one recommendation on a systemic issue that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight an area of concern, and the recommendation is intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. The recommendation is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

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

Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) affiliated medical center reporting to VISN 10.[1]

Table B.1. Profile for Battle Creek VA Medical Center (515)
(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	$406,395,682	$449,388,433	$496,958,869
Number of:			
• Unique patients	42,338	43,523	44,205
• Outpatient visits	489,789	535,211	523,309
• Unique employees§	1,402	1,399	1,444
Type and number of operating beds:			
• Community living center	109	109	109
• Domiciliary	92	92	92
• Medicine	11	11	0
• Mental health	55	55	29
• Residential rehabilitation	9	9	9
Average daily census:			
• Community living center	73	59	49
• Domiciliary	51	42	38
• Medicine	5	3	1
• Mental health	36	24	24

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

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census, cont.:			
• Residential rehabilitation	4	1	4

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

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

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

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 1, 2024

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

Subj: Comprehensive Healthcare Inspection of the Battle Creek VA Medical Center in Michigan

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

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

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

(Original signed by:)

Laura E. Ruzick, FACHE

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: January 29, 2024

From: Executive Medical Center Director, Battle Creek VA Medical Center (515)

Subj: Comprehensive Healthcare Inspection of the Battle Creek VA Medical Center in Michigan

To: Director, VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. I have reviewed the draft report – Comprehensive Healthcare Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan. We concur with the findings and recommendations.
2. I appreciate the opportunity for this review as a continuing process to improve the care to our Veterans. Thank you.

(Original signed by:)

Michelle Martin
Executive Medical Center Director

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