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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Minneapolis VA Health Care System in Minnesota

CHIP Report	23-00018-83	February 27, 2024

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Figure 1. *Minneapolis VA Medical Center of the Minneapolis VA Health Care System in Minnesota.*

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

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

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

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

The OIG initiated an unannounced inspection of the Minneapolis VA Health Care System during the week of March 20, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted an opportunity for improvement and issued one recommendation to the Chief of Staff in the Mental Health area of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The result is detailed in the report section, and the recommendation is presented in appendix A on page 17.

VA Comments

The Veterans Integrated Service Network Director and Healthcare System Director agreed with the comprehensive healthcare inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, pages 20–21, and the response within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendation until they are completed.

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Purpose and Scope

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

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

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

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

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

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

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

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

Methodology

The Minneapolis VA Health Care System includes the Minneapolis VA Medical Center and multiple outpatient clinics in Minnesota and Wisconsin. General information about the healthcare system can be found in appendix B.

The OIG inspected the Minneapolis VA Health Care System during the week of March 20, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendation for improvement addresses a problem that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Healthcare System 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 Minneapolis VA Health Care System occurred in May 2017. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in September 2022.

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

Results and Recommendations

Leadership and Organizational Risks

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

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

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director; Chief of Staff; Associate Director for Patient Care Services (ADPCS); Associate Director, Operations; and Associate Director, Chief Experience Officer. 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 Associate Director, Operations and Director were the most tenured executive team leaders, serving for about 16 and 12 years, respectively. The ADPCS had served in the role a little over 2 years. The newest team members were the Chief of Staff and Associate Director, Chief Experience Officer, who had been in their positions for less than 1 year.

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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; Associate Director, Operations; and Associate Director, Chief Experience Officer regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $1,283,842,618 had decreased by approximately 1 percent compared to the previous year's budget of $1,297,678,206.[10] The Director stated the budget was adequate to support the healthcare system's needs over the last three years, adding that leaders had focused on returning veterans from community care to the healthcare system to minimize costs.[11] According to the associate directors, some of the budget supported recruitment and retention for staff positions in areas such as food and environmental management services. The Chief of Staff stated the healthcare system's funds were adequate for acquiring state-of-the-art medical equipment but challenging for recruiting providers, who are paid higher salaries in the community.

Employee Satisfaction

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

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

The Associate Director, Chief Experience Officer discussed staff trust in the executive leadership team as a factor contributing to the healthcare system's scores, which were higher than VHA's for all three FYs. The associate directors described leaders' increased visibility through regular visits to staff throughout the healthcare system and their continuous enforcement of high-

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

[11] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed January 25, 2023, https://www.va.gov/communitycare/.

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

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

reliability organization principles, which have built trust.[14] Similarly, the ADPCS stated high-reliability organization tiered huddles and employees' ability to elevate concerns to leaders and receive responses had increased trust.[15]

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
Minneapolis VA Health Care System	4.0	4.0	4.0

Source: VA All Employee Survey (accessed November 15, 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.[16] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

Survey results indicated patients were more satisfied with their inpatient experiences at this healthcare system compared to VHA patients nationally; however, satisfaction declined over time. Leaders discussed how shared patient rooms negatively affected the patient experience. The Director said the healthcare system had more shared hospital rooms than any other VA facility, and the Chief of Staff added that single rooms were part of current patient expectations. The associate directors stated that converting all double or four-bed rooms to private rooms was

[14] High-reliability organizations promote psychological safety for staff to discuss and resolve patient safety issues. Naseema Merchant et al., "Creating a Process for the Implementation of Tiered Huddles in a Veteran Affairs Medical Center," *Military Medicine* 188, no. 5-6 (May-June 2023): 6, https://academic.oup.com/milmed/advance-article/doi/10.1093/milmed/usac073/6551253.

[15] A high-reliability organization uses a tiered reporting structure to identify and resolve patient safety issues. "Tiered huddles consist of a series of brief (typically no more than 15 minutes), focused, and transparent forums including frontline staff all the way to the senior leadership to proactively identify, share, and address safety concerns, staffing levels, resource allocation, operational issues, and more across an entire organization or healthcare system." Merchant et al., "Creating a Process for the Implementation of Tiered Huddles in a Veteran Affairs Medical Center."

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

part of the healthcare system's six-to-seven-year plan. The leaders also shared a pamphlet called *Journey to Discharge* designed to enhance the inpatient experience by educating patients on the steps involved in preparing for discharge.

Survey results also indicated patients were satisfied with their primary and specialty care experiences. The Chief of Staff explained staff were mission oriented and provided outstanding care. The Director reported leaders had added a physical therapist, nutritionist, and social worker to primary care teams, which provided more services and enhanced the responses to patients' needs. The Chief of Staff highlighted patients' access to all specialty services within the healthcare system as a contributor to high satisfaction.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	74.6	69.7	74.3	68.9	72.6
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†*	82.5	88.9	81.9	89.9	81.7	88.6
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†*	84.8	89.4	83.3	89.5	83.1	87.0

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (Inpatient values accessed December 14, 2022; Patient-Centered Medical Home and Specialty Care values accessed December 8, 2022).

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[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. When asked about the patient safety reporting process at the healthcare system, the Director, ADPCS, and Chief of Staff said staff report patient safety events through the Joint Patient Safety Reporting system.[24] The ADPCS and Chief of Staff explained that patient safety staff review Joint Patient Safety Reporting system entries daily, report incidents during leadership huddles, recommend further evaluation as needed such as peer reviews or root cause analyses, and assign staff to complete the evaluations, with oversight from the Chief of Staff and ADPCS. The Director also said patient safety staff track each event until employees implement all recommended actions.

Quality management staff also discussed use of the Joint Patient Safety Reporting system to capture patient safety events. Further, they described efforts to strengthen the feedback loop and increase staff reporting by communicating outcomes of the reviewed events to the submitters. The Director, ADPCS, and Chief of Staff stated the Chief of Staff managed the institutional disclosure process in collaboration with the Risk Manager.

The ADPCS and Chief of Staff also discussed staff event reporting through high-reliability organization tiered huddles. The Chief of Staff added that tiered huddles provided a method for staff to raise potential systems issues; for example, staff might report ice in the parking lot during a tiered huddle versus reporting a fall on the ice through the Joint Patient Safety Reporting system.

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 May 15, 2023, https://www.patientsafety.va.gov/about/faqs.asp.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[25] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[27]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[28] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[29]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[30] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[31] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[32]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed 16 deaths 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.

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

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

[27] VHA Directive 1100.16.

[28] VHA Handbook 1050.01; VHA Directive 1050.01.

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

[30] A peer review is a "critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[31] VHA Directive 1190.

[32] VHA Directive 1190.

Medical Staff Privileging

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

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

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

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

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

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Directive 1100.20.

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

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

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

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

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[40] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[41]

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

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

- Community Living Centers (1E and 1F)
- Dental Clinic
- Emergency Department
- Inpatient Mental Health unit (1L)
- Intensive care units (medical and surgical)

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 states that providers should complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.[50] The OIG estimated that providers did not complete the evaluation at all or on the same calendar day for 24 (95% CI: 12 to 36) percent of patients with positive screens, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[51] Failure to evaluate patients for suicidal behavior, or evaluate them promptly, could result in missed opportunities for providers to identify patients at imminent risk for suicide and intervene. The Acting Chief, Mental Health and the Associate Director, Primary Care and Specialty Medicine Integrated Clinical Community said that inconsistent naming of the Comprehensive Suicide Risk Evaluation template within the electronic health record affected providers' ability to find and complete the evaluation.

Recommendation 1

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

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

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

Healthcare system concurred.

Target date for completion: 2/29/2024

Healthcare system response: Prior to the OIG CHIP visit, it was recognized that the compliance rate for completing the Comprehensive Suicide Risk Evaluation (CSRE), when a suicide screen was positive, had fallen to 89% in December 2022. The Suicide Prevention Program Team evaluated the process. One of the root causes for non-compliance was the inconsistent naming of the CSRE template within the electronic health record affecting the provider's ability to find and complete the evaluation. Nationally, VA sites are required to use the "Suicide Risk Evaluation-Comprehensive" as the note title despite the document being called "CSRE." Since the note title cannot be changed, the search function of "CSRE" was integrated into CPRS to improve the likelihood that staff will find the correct template for documenting.

Another root cause was the lack of consistent education and accountability for the requirement when a suicide screen is positive. The Assistant Chief of Primary Care provided education and training on how to complete the CSRE in the clinic setting. This occurred with the Patient Aligned Care Teams (PACT) in the ambulatory clinics in April 2023. The Primary Care Mental Health Integration Coordinator provided education and presented available resources during clinic meetings and daily huddles with the PACT providers on the warm handoff process. This was completed in May 2023. To support new providers as well as providing resources, the Primary Care Mental Health Integration Coordinator will hold open office hours quarterly. This process will begin FY24 Quarter 2.

To build a system that is highly reliable, the following processes have been implemented. The Suicide Prevention Team tracks compliance daily utilizing the Ambulatory risk ID report dashboard to ensure CSREs are completed. In CPRS, under Team, the Suicide Prevention Team can pull up and review positive suicide screens that occurred without a CSRE on same day. If a suicide screen is positive, and a CSRE is not completed, the Suicide Prevention Team reaches out to the provider to ensure that it is completed on the same day. This process began in May 2023. The Suicide Prevention Coordinator (SPC) provides a Suicide Risk ID report, which included CSRE completion compliance to the Quality Management Council (QMC) quarterly.

Since August 2023, the compliance rate for completion of the CSRE for a positive suicide screen within the required timeframe has been consistently ≥90%. The organization will continue to monitor compliance rate monthly as part of the sustainability plan. The SPC continues to monitor compliance daily and follow-up occurs with individual providers.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

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

Appendix B: Healthcare System Profile

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

Table B.1. Profile for Minneapolis VA Health Care System (618) (October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$1,144,452,075	$1,297,678,206	$1,283,842,618
Number of:			
• Unique patients	101,118	110,739	104,342
• Outpatient visits	892,237	1,081,867	988,162
• Unique employees§	3,900	4,073	3,989
Type and number of operating beds:			
• Community living center	80	80	80
• Medicine	96	96	96
• Mental health	24	24	24
• Rehabilitation medicine	28	28	28
• Surgery	49	49	49
Average daily census:			
• Community living center	49	46	48
• Medicine	74	87	94
• Mental health	14	11	9
• Rehabilitation medicine	15	16	16

[1] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "with high-volume, high-risk patients, most complex clinical programs, and large 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.

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census, cont.:			
• Surgery	20	20	16

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 5, 2024

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

Subj: Comprehensive Healthcare Inspection of the Minneapolis VA Health Care System in Minnesota

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

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

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

(Original signed by:)

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

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: February 7, 2024

From: Director, Minneapolis VA Health Care System (618)

Subj: Comprehensive Healthcare Inspection of the Minneapolis VA Health Care System in Minnesota

To: Director, Office of Healthcare Inspections (54CH02)
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

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

(Original signed by:)

Patrick J. Kelly, FACHE

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