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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Black Hills Health Care System in Fort Meade, South Dakota

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Figure 1. *Fort Meade VA Medical Center of the VA Black Hills Health Care System in South Dakota.*

Source: https://www.va.gov/black-hills-health-care/locations/ (accessed November 30, 2022).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Black Hills Health Care System, which includes the Fort Meade and Hot Springs VA Medical Centers and multiple outpatient clinics in Nebraska, North Dakota, South Dakota, and Wyoming. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

The OIG initiated an unannounced inspection of the VA Black Hills Health Care System during the week of August 21, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued four recommendations to the 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 system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality

health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 20.

VA Comments

The Veterans Integrated Service Network Director and the Acting Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 22–23, 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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Contents

Purpose and Scope

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

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

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

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

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

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

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

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

Methodology

The VA Black Hills Health Care System includes the Fort Meade and Hot Springs VA Medical Centers and multiple outpatient clinics in Nebraska, North Dakota, South Dakota, and Wyoming. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review during the week of August 21, 2023.[5] During 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 healthcare system leaders complete corrective actions. The Acting 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 VA Black Hills Health Care System occurred in August 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, 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 slightly over one year. The newest member was the ADPCS, who was assigned in May 2022, and the most tenured was the Associate Director, assigned in July 2020.

[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 Associate Director 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 $356,625,506 had increased nearly 14 percent compared to the previous year's budget of $314,092,544.[10] The Director and Associate Director reported using financial resources for recruitment and retention incentives. The Chief of Staff said competing for doctors, nurses, physician assistants, and nurse practitioners was difficult because of the limited number of potential candidates in the area. The Associate Director also described challenges hiring and retaining staff due to a large casino nearby offering higher pay. The Director reported higher costs for supplies and construction, and the Chief of Staff added the healthcare system needed the increased budget to maintain two large campuses with 100-year-old buildings.

Employee Satisfaction

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

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

The healthcare system's scores were similar to VHA averages each year, remaining stable from FY 2020 to FY 2021 and increasing slightly in FY 2022. To improve staff comfort with reporting violations, the Director discussed executive leaders holding regular meetings for all staff to share information and ask questions. The Director further described implementing a standardized presentation at new employee orientation that emphasized the importance of diversity and unity and the commitment to being a high-reliability organization.[13]

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

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

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

[13] A high-reliability organization "is an organization with a goal of achieving 'zero harm' in an environment where accidents are expected due to complexity or risk factors." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program,* December 12, 2019.

The ADPCS reported starting quarterly meetings for nurse managers and monthly meetings for all nurses as part of leaders' initiatives to increase employee engagement. The Associate Director said service chiefs were now addressing issues when they arise, which has been a major culture change, but staff were seeing the results.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
VA Black Hills Health Care System	3.8	3.8	3.9

Source: VA All Employee Survey (accessed January 3, 2023).

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

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the 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 and outpatient care than VHA patients overall. To sustain and continue to improve patient satisfaction, the Director reported meeting with veterans service organizations and attending townhalls, listening to concerns, and acting on issues. As an example, the Director described the resolution of a transportation problem in rural Wyoming in which discussions with a Disabled American Veterans' liaison resulted in volunteers driving veterans to and from appointments. Additionally, the Director reported that all leaders are expected to walk around the facility to speak with veterans. The ADPCS reported directing nurses to check on inpatients every hour, make post-discharge phone calls, and increase telehealth services to improve patients' experiences.

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

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	78.2	69.7	79.1	68.9	83.4
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	82.5	90.2	81.9	89.7	81.7	90.1
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	93.3	83.3	91.1	83.1	91.2

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

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

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[15] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[16] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

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

[16] 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.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[17]

"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)."[18] 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."[19] 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."[20] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[21]

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 Chief of Staff and ADPCS explained that staff identify adverse events and elevate them to leaders through meetings or entries in an electronic patient safety database. A facility leader reported being approached by staff members with patient safety events and encouraging them to enter the events into the electronic database, but then instead entering the information into the database on behalf of the employees for efficiency. However, the Director said the Patient Safety Manager had re-educated staff on the importance of entering these events themselves to ensure accuracy of the reported incident.

The Chief of Staff and ADPCS described reviewing all events with the Patient Safety Manager and staff from Quality, Safety, Value and the Chief of Staff office. The Director also reported using VHA policies and directives to determine whether to classify adverse events as sentinel events. The Chief of Staff and ADPCS added that leaders conduct institutional disclosures for adverse events as required by VHA.

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

[18] 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.

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

[20] VHA Directive 1004.08.

[21] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

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.[22] 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.[23] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[24]

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.[25] 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.[26]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[27] 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."[28] 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.[29]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed two deaths that occurred within 24 hours of inpatient admission, and staff reported no suicides had 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.

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

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

[24] VHA Directive 1100.16.

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

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

[27] 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.

[28] VHA Directive 1190.

[29] 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."[30] 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."[31]

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

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation (OPPE) to ensure the continuous delivery of quality care.[34]

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.[35] 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

[30] 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.)

[31] VHA Handbook 1100.19.

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[36]

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 regularly complete an OPPE for each LIP.[37] The OIG did not find documentation that service chiefs consistently completed OPPEs. This may have resulted in LIPs providing patient care without a timely competency evaluation, which could adversely affect quality of care. VHA also requires an executive committee of the medical staff to review OPPE data and document its review prior to recommending ongoing privileges to the Director.[38] The OIG found the Executive Committee of the Medical Staff documented its review of OPPE data even though some LIPs' folders did not contain these evaluations. The executive committee's failure to review evaluations but document they did may undermine the integrity of the reprivileging process. The Chief of Staff attributed the incomplete OPPEs to service chiefs having multiple competing priorities and prioritizing clinical care over administrative duties.

Recommendation 1

1. The Chief of Staff ensures service chiefs regularly complete Ongoing Professional Practice Evaluations for each licensed independent practitioner.

Healthcare system concurred.

Target date for completion: July 31, 2024

Healthcare system 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 Quality and Patient Safety Committee until 90 percent compliance is achieved and sustained for six consecutive months.

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

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

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

Recommendation 2

2. The Chief of Staff ensures the Executive Committee of the Medical Staff reviews Ongoing Professional Practice Evaluation data and documents its review prior to recommending licensed independent practitioners' ongoing privileges to the Director.

Healthcare system concurred.

Target date for completion: July 31, 2024

Healthcare system response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Executive Committee of the Medical Staff will review the Ongoing Professional Practice Evaluation data and documents it's review prior to recommending licensed independent practitioners' ongoing privileges to the Medical Center Director. The credentialing and privileging staff will track and monitor Ongoing Professional Practice Evaluations. The Credentialing and Privileging Manager will report the compliance results monthly to the Quality and Patient Safety Committee until 90 percent compliance is achieved and sustained for six consecutive months.

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

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.[41]

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

- Fort Meade VA Medical Center
    - Community Living Center (G)
    - Emergency Department
    - Inpatient Mental Health Unit[42]
    - Intensive Care Unit
    - Medical/Surgical Inpatient Unit
    - Women's Clinic

[39] 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.)

[40] 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. The directives contain similar language related to the supply chain management system.) VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[41] 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.)

[42] The OIG did not comment on or make recommendations for the Inpatient Mental Health Unit because the Nurse Manager reported the unit would close for construction after the on-site inspection on August 22, 2023.

- Hot Springs VA Medical Center
  - Acute and Community Living Center (1 East)
  - Primary Care Clinic
  - Urgent Care Center

Environment of Care Findings and Recommendations

VHA requires staff to conduct environmental inspections at "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is delivered."[43] The OIG reviewed environmental inspection reports and found staff did not inspect patient care areas at least twice during FY 2022. Additionally, to determine whether staff complied during FY 2023, the OIG requested and reviewed relevant documents and found staff did not inspect all community-based outpatient clinics twice in FY 2023. Failure to inspect patient care areas could hinder staff from proactively identifying unsafe conditions. The Associate Director reported that staffing issues and COVID-19 pandemic restrictions negatively affected the frequency of inspections.

Recommendation 3

3. The Director ensures staff complete environment of care inspections at the required frequency.

Healthcare system concurred.

Target date for completion: July 31, 2024

Healthcare system 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 Industrial Hygiene and Safety Manager 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 Industrial Hygiene and Safety Manager will report the compliance rate monthly to the Quality and Patient Safety Committee which is chaired by the Medical Center Director until 90 percent compliance is achieved and sustained for six consecutive months.

[43] VHA Directive 1608.

VHA requires all medical facilities to ensure a safe and clean environment of care.[44] In six of the nine areas inspected, the OIG found one or more of the following: wall damage, stained ceiling tiles, and ice machines with residue. The OIG also observed equipment intended for patient use stored on the floor, uncovered linen and debris on a blanket warmer in a clean supply room, and clean and dirty items stored in the same space. Dirty and damaged patient care areas increase the risk of contamination and pathogen exposure. The charge nurse on the Medical/Surgical Inpatient Unit attributed some wall damage to the installation and removal of exhaust systems during the COVID-19 pandemic. The Industrial Hygiene and Safety Manager attributed some wall damage to a lack of clearance for carts delivering supplies. The Engineering Program Manager described ongoing construction, which could have contributed to debris observed on the blanket warmer. The nurse managers were unable to explain why staff stored equipment on the floor and clean and dirty items together. Because leaders had already taken action to correct the deficiencies during the site visit and planned to monitor for compliance in FY 2024, the OIG did not make a recommendation.

[44] VHA Directive 1608.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[45] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[46] The suicide rate for veterans was higher than for nonveteran adults during 2020.[47] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[48]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[49] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[50]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[51]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 41 patients who had a positive suicide screen in FY 2022 and received primary care services.

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

[46] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

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

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

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

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

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

Mental Health Findings and Recommendations

VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as a patient's positive suicide risk screen in all ambulatory care settings.[52] The OIG found providers did not complete the evaluation following a positive screen for 44 percent of patients. Failure to promptly evaluate patients following a positive screen could result in missed opportunities for providers to identify those at imminent risk for suicide and intervene. The Suicide Prevention Coordinator stated providers documented the results of a depression screening tool as an evaluation of suicide risk instead of completing the Comprehensive Suicide Risk Evaluation, believing this met the intent of the requirement.

Recommendation 4

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

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

Healthcare system concurred.

Target date for completion: July 31, 2024

Healthcare system 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.

The Standard Operating Procedure was reviewed during the All-PACT Meeting on 12/14/2023.

All PACT Social workers, Primary Care Mental Health Integrate (PCMHI) Psychologists, and Suicide Prevention Team members are view alerted to positive Columbia-Suicide Severity rating Scale Screener (C-SSRS) to facilitate awareness of positive screens and proactively outreach to screener to assist with completion of CSRE on the same day.

All patient Aligned Care Teams (PACT) staff are added to a Microsoft Teams group to request assistance with CSRE completion as a back-up process when the responsible PCMHI/PACT Social Worker is unavailable. The Suicide Prevention Team or other available Social Workers responds to the outreach requests to coordinate a warm hand-off by phone, video, or face to face with the Veteran to complete the CSRE.

PACT Administrative Officer added Suicide Prevention Orientation to the new Primary Care Provider orientation and schedules new Primary Care Providers to meet with the Suicide Prevention for an overview of the Risk Identification Strategy during onboarding.

Suicide Prevention team orients all new nursing staff to Suicide Risk Identification Strategy during New Nursing Orientation.

The Suicide Prevention team monitors the ambulatory care fallout dashboard daily and follows up with clinical providers and managers about fallouts to ensure Comprehensive Suicide Risk Evaluations are completed timely or as soon as possible after fallout.

Suicide Prevention Coordinator reviews data with all integrated Clinical Committee's (ICC's) monthly.

The Suicide Prevention Team maintains helpful resources, tips, and toolkits for the health Care System that are accessible on the facility SharePoint site, with a direct link provided in the tools menu in CPRS.

The Suicide Prevention Coordinator will provide a quarterly report for compliance with a completed Comprehensive Suicide Risk Evaluation (CSRE) for every positive Columbia Severity Rating Scales (C-SSRS) will be submitted to the Quality and Patient Safety Committee, which is chaired by the Medical Center Director, until 90% Compliance has been achieved for two consecutive quarters.

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines four OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the 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 regularly complete Ongoing Professional Practice Evaluations for each licensed independent practitioner. • The Executive Committee of the Medical Staff reviews Ongoing Professional Practice Evaluation data and documents its review prior to recommending licensed independent practitioners' ongoing privileges to the Director.
Environment of Care	• Staff complete environment of care inspections at the required frequency.
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation the same calendar 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 medium complexity (2) affiliated healthcare system reporting to VISN 23.[1]

Table B.1. Profile for VA Black Hills Health Care System (568) (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	$283,207,840	$314,092,544	$356,625,506
Number of:			
• Unique patients	19,205	19,976	20,754
• Outpatient visits	207,925	234,770	248,825
• Unique employees§	901	917	870
Type and number of operating beds:			
• Community living center	104	104	104
• Domiciliary	112	112	72
• Hospital	34	34	34
Average daily census:			
• Community living center	49	39	32
• Domiciliary	44	32	43
• Hospital	10	12	12

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

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

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

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

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

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

[1] VHA medical facilities are classified according to a complexity model; a designation of "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 7, 2024

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

Subj: Comprehensive Healthcare Inspection of the VA Black Hills Health Care System in Fort Meade, South Dakota

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

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection draft report of the Black Hills VA Health Care System. I concur with the recommendations outlined in this report.
2. Black Hills 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 Heath Care Network (VISN 23)

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: February 28, 2024

From: Director, VA Black Hills Health Care System (568)

Subj: Comprehensive Healthcare Inspection of the VA Black Hills Health Care System in Fort Meade, South Dakota

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

1. I wish to extend my thanks to the Office of Inspector General (OIG) Healthcare Inspection Team for the professional review of the organization that was completed. I have reviewed the draft report and concur with the findings and recommendations.
2. Attached are the facility responses to the four (4) recommendations, including actions that are in progress to correct the identified opportunities for improvement.

(Original signed by:)

Spencer Mion, MHA, MBA, FACHE, CPO
Acting Medical Center Director

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