DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Summary Report: Evaluation of Medical Staff Privileging in Veterans Health Administration Facilities, Fiscal Year 2020

CHIP REPORT | REPORT #21-01503-112 | MARCH 28, 2022

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Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FPPE	focused professional practice evaluation
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
SLB	state licensing board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years. The OIG selects and evaluates specific areas of focus each year.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected medical staff privileging program requirements for processes related to focused professional practice evaluation, ongoing professional practice evaluation, state licensing board reporting, and provider exit review forms.

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. These inspections involved interviews with key managers and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG inspections and may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.[1]

Inspection Results

The OIG identified deficiencies with focused and ongoing professional practice evaluation, provider exit review, and state licensing board reporting processes. Specifically,

- use of minimum criteria for selected specialty licensed independent practitioners' focused professional practice evaluations,[2]
- inclusion of service-specific criteria in ongoing professional practice evaluations,
- completion of ongoing professional practice evaluations by other providers with similar training and privileges,
- recommendation by executive committees to continue licensed independent practitioners' privileges based on professional practice evaluation results,
- completion of provider exit review forms within seven business days of licensed independent practitioners' departure from a medical facility,

[1] Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

[2] Acting Deputy Under Secretary for Health for Operations and Management Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

- signing of exit review forms by service chiefs, chiefs of staff, and medical facility directors if licensed healthcare professionals failed to meet generally-accepted standards of care, and
- initiation of state licensing board reporting within seven business days of supervisors' signatures on exit review forms to indicate licensed healthcare professionals failed to meet generally-accepted standards of care.

The OIG found continued issues from the fiscal year 2019 CHIP summary report that warranted repeat recommendations for improvement.[3] The OIG issued three repeat recommendations related to the

- inclusion of minimum specialty criteria for focused professional practice evaluations,
- inclusion of service-specific criteria in ongoing professional practice evaluations, and
- recommendation by executive committees of the medical staff in continuing licensed independent practitioners' privileges based on professional practice evaluation results.[4]

Conclusion

The OIG conducted detailed inspections at 36 VHA medical facilities to ensure leaders implemented medical staff privileging processes in compliance with requirements. The OIG subsequently issued six recommendations for improvement to the Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders. The intent is for VHA leaders to use these recommendations to help guide improvements in operations and clinical care at the facility level. The recommendations address findings that may eventually interfere with the delivery of quality health care.

[3] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, Report No. 20-01994-18, November 24, 2020.

[4] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.

VA Comments and OIG Response

The Deputy Under Secretary for Health, Performing the Delegable Duties of Under Secretary for Health, concurred with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix C, pages 17–18, and the responses within the body of the report for the full text of the executive's comments.) The OIG addressed the comments and made one change to add VHA's new information in the report (see addendum to appendix C, page 19). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

While the OIG selects and evaluates specific areas of focus on a rotating basis each year, the evaluation of staff credentialing or privileging in VHA facilities is an ongoing review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.[1] These leaders are directly accountable for program integration and communication within their level of responsibility.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected medical staff privileging requirements for processes related to focused professional practice evaluation (FPPE), ongoing professional practice evaluation (OPPE), state licensing board (SLB) reporting, and provider exit reviews.

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently…without supervision, direction…within the scope of the individual's license…and in accordance with individually-granted clinical privileges."[2] The healthcare professional is "also referred to as a licensed independent practitioner (LIP)."[3]

Clinical privileges must be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the executive committee of the medical staff and approved by the facility director. "Clinical privileges are granted for a period not to exceed two years," and LIPs must undergo reprivileging prior to their expiration.[4]

VHA defines the FPPE as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[5] The FPPE process

[1] Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. No. 111-163, § 505 (2010).

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (The credentialing portion of this handbook has been superseded by VHA Directive 1100.20, *Credentialing of Healthcare Providers*, September 15, 2021. However, the new directive does not change the credentialing criteria as discussed in this report.)

[3] VHA Handbook 1100.19.

[4] VHA Handbook 1100.19.

[5] VHA Handbook 1100.19.

occurs when a provider is hired at the facility and granted initial privileges, before any new clinical privileges are granted. VHA facility leaders must continuously monitor the performance of their providers using objective criteria. Monitoring can involve activities "such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process."[6] VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[7] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[8]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Inclusion of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[9]
  - Evaluation by another provider with similar training and privileges

The OIG determined whether service chiefs recommended continuing LIPs' current privileges based in part on the results of professional practice evaluation activities, and if facilities' executive committees of the medical staff decided to recommend continuing privileges based on FPPE and OPPE results.

VHA must have processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former LIP's clinical practice, VA has an obligation to notify SLBs and subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[10] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert

[6] VHA Handbook 1100.19.

[7] VHA Handbook 1100.19.

[8] Acting Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

[9] Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners*.

[10] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. (This handbook was rescinded January 28, 2021, and replaced with VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*. The two documents contain similar language related to SLB requirements.)

(SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[11] The OIG reviewers assessed whether VHA staff

- designated an individual and backup responsible for the SLB reporting process,
- completed forms within the required time frame and with required oversight, and
- reported results to SLBs when indicated.

The results in this summary report are a snapshot of national-level VHA performance at the time of the fiscal year 2020 OIG inspections and may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.[12]

[11] VHA Notice 2018-05, *Amendment to VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards*, February 5, 2018. (VHA Directive 1100.18 requires the "Credentialing and Privileging program manager to be responsible for the [SLB] reporting process and oversight of timely completion of exit reviews." The new directive also revises the requirement for exit review forms to be completed within seven calendar days to seven business days.)

[12] Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

Methodology

To determine whether VHA facilities complied with medical staff privileging requirements, the OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks.

To determine whether VHA facilities implemented and incorporated OIG-selected medical staff privileging processes into local activities, the OIG interviewed key managers and selected and reviewed the privileging folders of 1,521 medical staff members who underwent clinical privileging, or left the inspected medical facility, from November 4, 2018, through December 31, 2019.

The OIG published individual CHIP reports for each facility. For this report, the OIG analyzed data from the individual facility reviews to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. The comments and action plans submitted by the Deputy Under Secretary for Health, Performing the Delegable Duties of Under Secretary for Health, in response to the report recommendations appear within the report. The OIG accepted the action plans that VHA leaders developed based on the reasons for noncompliance.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[13] 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.

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.

[13] Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

VHA has defined procedures for clinical privileging of healthcare professionals. To determine whether VHA complied with requirements, the OIG interviewed key managers and selected and reviewed the privileging folders of the following medical staff members who underwent clinical privileging and those who left the medical facility from November 4, 2018, through December 31, 2019:

- 152 solo/few practitioners who underwent initial or reprivileging[14]
- 277 LIPs who had a completed FPPE
- 535 LIPs who were reprivileged
- 557 LIPs who left the medical facility

Findings and Recommendations

The OIG identified deficiencies with FPPE, OPPE, provider exit review, and SLB reporting processes.

VHA requires "criteria for the FPPE process…to be defined in advance, using objective criteria accepted by the practitioner."[15] In 110 of 296 practitioner profiles (37 percent), the OIG did not find evidence that criteria were defined in advance.[16] This could result in LIPs misunderstanding the FPPE expectations. Reported reasons for noncompliance included managers being unaware of the requirement, a lack of oversight, and beliefs that facility efforts met requirements.

Failure to communicate criteria to practitioners in advance of FPPEs is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.[17] Improvement

[14] Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners.* This memorandum refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers few practitioners as being less than three providers in the facility that are privileged in a particular specialty. This memorandum was in place during the time of the events discussed in this report. It was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's *Revision Memo: Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators* on May 18, 2021. VHA previously required that service chiefs include the minimum specialty-specific criteria for professional practice evaluations of gastroenterology, nuclear medicine, pathology, and radiation oncology solo practitioners and the new memorandum defines specialty-specific clinical indicators for over 30 specialties.

[15] VHA Handbook 1100.19.

[16] The finding includes 5 of 19 solo/few practitioners' profiles (26 percent).

[17] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, Report No. 20-01994-18, November 24, 2020.

actions from the fiscal year 2019 report remain in progress, and therefore, the OIG made no related recommendation.[18]

VHA requires that service chiefs include the minimum specialty-specific criteria for professional practice evaluations of gastroenterology, nuclear medicine, pathology, and radiation oncology practitioners.[19] The OIG found that 5 of 14 FPPEs (36 percent) and 10 of 48 OPPEs (21 percent) did not include the minimum criteria required by VHA for the specialty.[20] This resulted in practitioners providing care without a thorough evaluation of their competence. Reasons for noncompliance included managers reporting they were unaware of the requirement or lacked attention to detail.

The lack of minimum specialty criteria for FPPEs of gastroenterology, pathology, nuclear medicine, and radiation oncology practitioners is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.[21] The OIG closed the associated recommendation on June 3, 2021, based on evidence provided by VHA.[22] However, the OIG found continued issues that warranted a repeat recommendation for improvement.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures service chiefs include the minimum specialty criteria for focused professional practice evaluations of gastroenterology, pathology, nuclear medicine, and radiation oncology practitioners.

[18] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.

[19] Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners.* This memorandum was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's *Revision Memo: Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators* on May 18, 2021.

[20] The finding includes deficiencies for the 2 solo/few practitioners' FPPEs and 3 of 16 solo/few practitioners' OPPEs (19 percent).

[21] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.

[22] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.

VHA concurred.

Target date for completion: September 2022

Under Secretary for Health response: The Office of the Assistant Under Secretary for Health for Clinical Services (AUSHCS) updated requirements regarding minimum specialty criteria for focused professional practice evaluations (FPPE) through memorandum published May 18, 2021. The AUSHCS, along with the AUSH for Operations will ensure Veterans Integrated Service Networks (VISN), facilities and service chiefs include updated service-specific criteria in FPPEs for over 30 specialties, including gastroenterology, pathology, nuclear medicine, and radiation oncology.

Compliance with using service-specific criteria for monitoring clinical performance through FPPE are to be assessed through the facility self-assessment process. Facility specific results are to be reviewed by the respective VISN Chief Medical Officers and VISN Credentialing and Privileging Officers, including review and monitoring of action plans for areas of non-compliance, with verification by the AUSHCS and the AUSH for Operations.

VHA requires that service chiefs include relevant service-specific criteria in OPPEs.[23] For 92 of 668 OPPEs (14 percent), the OIG found insufficient evidence that criteria were specific to the practitioners' service.[24] This limited service chiefs' ability to evaluate competency specific to the care provided within the service and identify trends that may affect patient safety. Reasons for noncompliance included facility managers stating they believed efforts met the requirement, were unaware of requirement, and lacked adequate oversight.

The inclusion of service-specific criteria in OPPEs is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018* and *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.[25] The OIG closed the associated recommendation but found continued issues that warranted a repeat recommendation for improvement.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that service chiefs include service-specific criteria in ongoing professional practice evaluations.

[23] VHA Handbook 1100.19.

[24] The finding includes deficiencies for 38 of 133 solo/few practitioners' OPPEs (29 percent).

[25] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report No. 19-07040-243, October 10, 2019; VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.

VHA concurred.

Target date for completion: September 2022

Under Secretary for Health response: AUSHCS updated requirements regarding service-specific specialty criteria for ongoing professional practice evaluations (OPPE) through memorandum published May 18, 2021. The AUSHCS, along with the AUSH for Operations will ensure VISNs, facilities and service chiefs include updated service-specific criteria in OPPE for over 30 specialties.

Compliance with usage of service-specific criteria for monitoring clinical performance through OPPE are to be assessed through the facility self-assessment process. Facility specific results are to be reviewed by the respective VISN Chief Medical Officers and VISN Credentialing and Privileging Officers, including review and monitoring of action plans for areas of non-compliance, with verification by the AUSHCS and the AUSH for Operations.

VHA requires monitoring of privileged practitioners to assure quality care is delivered and patients are safe. "Evaluation of professional performance, judgment, and clinical and/or technical competence and skills is to be based in part on results of practitioner-specific performance improvement activities and data analysis," which may include monitoring diagnostic and treatment skills through electronic health record reviews for clinical pertinence, direct observations, and discussions.[26] The OIG found that service chiefs did not base their recommendations on any professional practice activities for 114 of the 668 LIPs reviewed (17 percent).[27] This allowed practitioners to continue delivering care without a thorough evaluation of their competence.

Of 276 practitioner FPPE profiles reviewed, the OIG found evidence that VHA service chiefs, or their designees, conducted

- periodic chart reviews in 269 profiles,
- direct observations in 58 profiles,
- diagnostic and treatment technique assessments in 18 profiles, and
- discussions with other individuals involved in the care of the patient in 25 profiles.

Further, in 554 practitioner OPPE profiles, 50 incorporated direct observation, 33 incorporated clinical discussions, and 455 incorporated clinical pertinence reviews. However, the OIG did not find evidence of review of any professional practice activities in 20 FPPEs and 114 OPPEs

[26] VHA Handbook 1100.19.

[27] This finding includes 17 of 133 solo/few practitioners (13 percent).

reviewed. Reasons for noncompliance included a lack of oversight and the stated belief that the data could not be kept as evidence because they were protected.

The failure of service chiefs to recommend the continuation of current privileges based in part on the results of OPPE activities is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.[28] The OIG agreed to close the associated recommendation on June 3, 2021, based on evidence provided by VHA. The OIG made no related recommendation because VHA provided evidence of compliance after the time frame of the fiscal year 2020 review.[29]

VHA also requires "another provider with similar training and privileges [to] evaluate the privilege-specific competence of the practitioner and document evidence of competently performing the requested privileges of the facility."[30] The OIG noted that 21 of 116 OPPEs for solo/few practitioners (18 percent) were not based on an evaluation by another provider with similar training and privileges. As a result, LIPs continued to deliver care without a thorough evaluation by others who provide similar healthcare services. Reasons for noncompliance included lack of oversight, lack of attention to detail, and that managers were unaware of requirements.

The failure to ensure that providers with similar training and privileges complete OPPEs is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019.*[31] Improvement actions from the fiscal year 2019 report remain in progress, and therefore, the OIG made no related recommendation.[32]

VHA also requires that executive committees of the medical staff recommend continuing LIPs' granted privileges based on FPPE and OPPE results. The committee's recommendation is then submitted to the medical center director for approval.[33] The OIG did not find evidence that executive committees of the medical staff recommended continuing privileges based on FPPE results for 65 of 296 LIPs (22 percent).[34] Further, the OIG did not find evidence that executive committees' recommendations to continue privileges were based on OPPE results for 152 of 668 LIPs (23 percent).[35] As a result, a significant number of LIPs continued to deliver care without thorough evaluations of their practices. Reported reasons for noncompliance included lack of oversight, lack of attention to detail, and managers' beliefs that facility efforts met requirements.

[28] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.
[29] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.
[30] Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners*.
[31] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.
[32] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.
[33] VHA Handbook 1100.19.
[34] This finding includes 4 of 19 solo/few practitioners (21 percent).
[35] This finding includes 32 of 133 solo/few practitioners (24 percent).

The failure to ensure executive committees of the medical staff recommended continuing LIPs' privileges based on OPPE results is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.[36] The OIG agreed to close the associated recommendation on June 3, 2021, based on evidence provided by VHA, but found continued issues that warranted a repeat recommendation for improvement.[37]

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures executive committees of the medical staff recommend continuing licensed independent practitioners' privileges based on professional practice evaluation results.

VHA concurred.

Target date for completion: April 2022

Under Secretary for Health response: Compliance with the expectation that consideration of OPPE results in the decision to reprivilege providers is to be documented within the minutes of the Executive Committee of the Medical Staff. Facilities will complete their self-assessments in January 2022 and results are to be aggregated by the end of the second quarter of FY [fiscal year] 22. Facility specific results are to be reviewed by the respective VISN Chief Medical Officers and VISN Credentialing and Privileging Officers including review and monitoring of action plans for areas of non-compliance. Additionally, results of these reviews and actions are to be monitored in aggregate through VHA Governance at the VHA Quality, Safety, and Value Council.

The OIG noted that during the time frame for this retrospective review, VHA required that "medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process."[38] The OIG found that 5 of 36 facilities (14 percent) failed to designate a backup individual responsible for the SLB reporting process. This may have resulted in delayed reporting of licensed healthcare professionals' potential substandard practices to SLBs. Reported reasons for noncompliance included staff being unaware of the requirement and a lack of oversight.

[36] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.
[37] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.
[38] VHA Notice 2018-05.

However, as of January 28, 2021, VHA required the "Credentialing and Privileging Program Manager to be responsible for the SLB reporting process and oversight of timely completion of exit reviews"; therefore, the OIG made no related recommendation.[39]

The OIG noted that during the time frame for this retrospective review, VHA required that provider exit review forms, which document the review of a provider's clinical practice, be "completed within 7 calendar days of the departure of a licensed health care professional from a VA facility."[40] The OIG found that 228 of 557 exit review forms (41 percent) were not completed within 7 calendar days of departure. However, as of January 28, 2021, VHA changed its requirement, and provider exit review forms are now to be completed within 7 business days.[41] Applying this updated requirement, the OIG found that 209 of 557 exit review forms (38 percent) were not completed within this new time frame. This may have resulted in delayed reporting of licensed healthcare professionals' potential substandard practices to SLBs. Reported reasons for noncompliance included leaders' lack of attention to detail and lack of oversight.

Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that provider exit review forms are completed within seven business days of licensed healthcare professionals' departure from a medical facility.

VHA concurred.

Target date for completion: September 2022

Under Secretary for Health response: VHA's Office of the Assistant Under Secretary for Health for Quality and Patient Safety, Office of Quality Management and the Office of Medical Staff Affairs will charter a workgroup to streamline and standardize the Exit Review form process including improved communication at the facility level of departure dates of licensed providers and standardization and automation of the Exit Review completion and routing process.

VHA also requires the service chief, service chief's supervisor, and facility director to sign the exit review form if the licensed healthcare professional failed to meet the generally-accepted standards of care.[42] The OIG found that among the 11 exit review forms that indicated providers failed to meet the generally-accepted standards of care, 4 (36 percent) were not signed by the service chief, the chief of staff, and director. Failure to sign exit review forms may lead to leaders being unaware of providers who are not meeting professional practice standards and

[39] VHA Directive 1100.18.

[40] VHA Notice 2018-05; VHA Directive 1100.18.

[41] VHA Directive 1100.18.

[42] VHA Notice 2018-05.

delay the initiation of appropriate action. Leaders reported reasons for noncompliance as a lack of attention to detail and lack of oversight.

Recommendation 5

5. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that provider exit review forms are signed by the service chief, the chief of staff, and the medical facility director if the licensed healthcare professional failed to meet the generally-accepted standards of care.

VHA concurred.

Target date for completion: September 2022

Under Secretary for Health response: VHA's Office of the Assistant Under Secretary for Health for Quality and Patient Safety, Office of Quality Management and the Office of Medical Staff Affairs will charter a workgroup to streamline and standardize the Exit Review form process including improved communication at the facility level of departure dates of licensed providers and standardization and automation of the Exit Review completion and routing process.

The OIG noted that during the time frame for this retrospective review, VHA required the SLB reporting process to be immediately initiated when a licensed healthcare professional failed to meet generally-accepted standards of care.[43] As of January 28, 2021, VHA requires the facility's credentialing and privileging manager to initiate the SLB reporting process within 7 business days of the supervisor's signature on the exit review form.[44] The OIG found that SLB reporting was not initiated for 7 of 11 licensed healthcare professionals (64 percent) whose exit review forms indicated a failure to meet generally-accepted standards of care. This delayed or lack of reporting resulted in a potential safety concern for patients treated by the healthcare professionals. Leaders reported that reasons for noncompliance were lack of attention to detail and lack of oversight.

[43] VHA Notice 2018-05.

[44] VHA Directive 1100.18.

Recommendation 6

6. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures credentialing and privileging managers initiate the state licensing board reporting process within the required time frame when licensed healthcare professionals fail to meet generally-accepted standards of care.

VHA concurred.

Target date for completion: March 2022

Under Secretary for Health response: VHA's Office of the Assistant Under Secretary for Health for Quality and Patient Safety, Office of Quality Management and the Office of Medical Staff Affairs modernized the Exit Review responsibility in VHA Directive 1100.18, Responding and Reporting to State Licensing Boards (SLB) published in January 2020 by assigning the Credentialing and Privileging (C&P) Managers' responsibility for reporting to SLBs. This policy clarification addressed previously identified causes of delay related to unclear duty assignments, specific to facility-level reporting to SLB. Training on the process of SLB reporting was provided to facility C&P Managers in July 2021; recording and training is available on the Medical Staff Affairs intranet site for ongoing reference.

VISN C&P Officers are to use the SLB/ National Practitioner Data Base tracker to monitor timeliness of reporting procedures. VISN C&P Officer positions were approved and mandated in 2021; VISN hiring was completed at the end of FY 2021. Training for the VISN C&P Officers is scheduled for completion in the second quarter of FY 2022.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines six OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The intent is for VHA leaders to use these recommendations as a road map to help guide improvements in operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Service chiefs include the minimum specialty criteria for FPPEs for gastroenterology, pathology, nuclear medicine, and radiation oncology practitioners. • Service chiefs include service-specific criteria in OPPEs. • Executive committees of the medical staff recommend continuing licensed independent practitioners' privileges based on professional practice evaluation results. • Provider exit review forms are completed within seven business days of licensed healthcare professionals' departure from a medical facility. • Provider exit review forms are signed by the service chief, chief of staff, and medical facility director if the licensed healthcare professional failed to meet the generally-accepted standards of care. • Credentialing and privileging managers initiate the state licensing board reporting process within the required time frame when licensed healthcare professionals fail to meet generally-accepted standards of care.	• None

Appendix B: Parent Facilities Inspected

Table B.1. Parent Facilities Inspected
(November 4, 2019, through September 21, 2020)

Names	City
VA Ann Arbor VA Healthcare System	Ann Arbor, MI
Charlie Norwood VA Medical Center	Augusta, GA
Battle Creek VA Medical Center	Battle Creek, MI
Birmingham VA Medical Center	Birmingham, AL
Boise VA Medical Center	Boise, ID
Ralph H. Johnson VA Medical Center	Charleston, SC
Jesse Brown VA Medical Center	Chicago, IL
Chillicothe VA Medical Center	Chillicothe, OH
Cincinnati VA Medical Center	Cincinnati, OH
Harry S. Truman Memorial Veterans' Hospital	Columbia, MO
Columbia VA Health Care System	Columbia, SC
VA Illiana Health Care System	Danville, IL
Dayton VA Medical Center	Dayton, OH
Atlanta VA Health Care System	Decatur, GA
John D. Dingell VA Medical Center	Detroit, MI
Carl Vinson VA Medical Center	Dublin, GA
Edward Hines, Jr. VA Hospital	Hines, IL
Oscar G. Johnson VA Medical Center	Iron Mountain, MI
Kansas City VA Medical Center	Kansas City, MO
William S. Middleton Memorial Veterans Hospital	Madison, WI
Marion VA Medical Center	Marion, IL
VA Northern Indiana Health Care System	Marion, IN
Milwaukee VA Medical Center	Milwaukee, WI
Central Alabama Veterans Health Care System	Montgomery, AL
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
John J. Pershing VA Medical Center	Poplar Bluff, MO
VA Portland Health Care System	Portland, OR
Roseburg VA Health Care System	Roseburg, OR
Aleda E. Lutz VA Medical Center	Saginaw, MI
VA Puget Sound Health Care System	Seattle, WA

Names	City
Mann-Grandstaff VA Medical Center	Spokane, WA
VA St. Louis Health Care System	St. Louis, MO
Tomah VA Medical Center	Tomah, WI
VA Eastern Kansas Health Care System	Topeka, KS
Tuscaloosa VA Medical Center	Tuscaloosa, AL
Robert J. Dole VA Medical Center	Wichita, KS

Source: VA OIG.

Appendix C: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: February 3, 2022

From: Deputy Under Secretary for Health, Performing the Delegable Duties of Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Medical Staff Privileging in Veterans Health Administration Facilities, Fiscal Year 2020 (Project No. 2021-01503-HI-1148) (VIEWS 6581482)

To: Assistant Inspector General for Healthcare Inspections (54)

1. The Veterans Health Administration (VHA), and specifically its Office of Clinical Services was pleased to engage with OIG on its review and welcomes the opportunity to identify areas for improvement. VHA concurs with the report and recommendations.
2. The Office of Clinical Services expended considerable resources and time to develop solutions to the concerns raised by OIG during its review. The Office of Clinical Services engaged a team of subject matter experts (SME) to develop a framework for specialty specific clinical indicators. In support of this effort, the Office of Diagnostic Services engaged a team of field-based SMEs to develop specific clinical indicators for clinical practice review of anatomic pathologists, diagnostic radiologists, interventional radiologists, and nuclear medicine physicians.
3. The Office of Clinical Services FPPE/OPPE NWG developed a VHA-level chart review template to standardize documentation for clinical chart reviews. This tool provides a systematic method to document the required clinical indicator data/information to include specialty-specific diagnoses/procedures and clinical evaluation criteria for each of the required clinical indicators.
4. VHA also notes that it proactively chartered a Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation (FPPE/OPPE) National Workgroup (NWG) that partnered with headquarters' Integrated Clinical Communities and program offices to develop, validate, and implement over 110 specialty-specific clinical indicators for over 30 specialties. VHA previously required that service chiefs include the minimum specialty-specific criteria for professional practice evaluations of gastroenterology, nuclear

medicine, pathology, and radiation oncology solo practitioners. The directing memorandum from August 2016 which required review of the specific specialties was rescinded in May 2021. This new information impacts content in OIG's draft report on page 5, paragraph 5.

5. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D.

Addendum to the Memorandum: OIG Response

The OIG appreciates the feedback from VHA and provides the following responses to the Deputy Under Secretary for Health's comments.

1. The OIG appreciates the Office of Clinical Services taking action to standardize specialty-specific clinical indicators for providers.
2. The OIG reviewed selected medical staff privileging program requirements from November 4, 2019, through September 21, 2020. At the time of the review, VHA required minimum specialty-specific criteria for professional practice evaluations for four specialties. The new memorandum defines specialty-specific clinical indicators for over 30 specialties. This latest information has been included in the report, but the OIG cannot provide comment on activities conducted after the time frame of the inspection.

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