DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network in Arlington

CHIP REPORT | REPORT #22-00044-142 | JUNE 27, 2023

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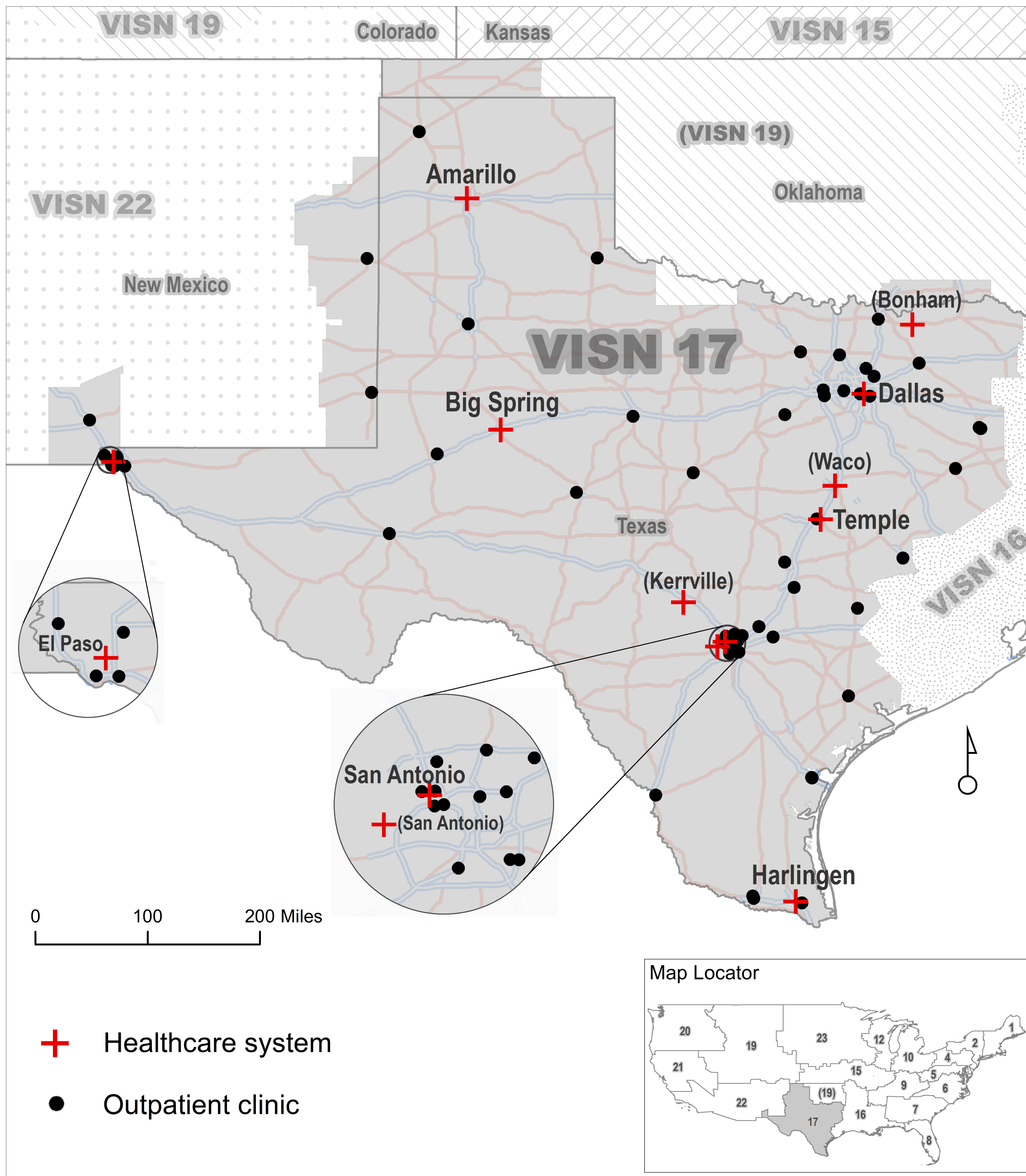

Figure 1. *Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network.*

Source: Veterans Health Administration Site Tracking System (accessed February 1, 2022).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CMO	Chief Medical Officer
FY	fiscal year
HCS	healthcare system or health care system
OIG	Office of Inspector General
VAMC	VA medical center
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 leadership performance and oversight by Veterans Integrated Service Network (VISN) 17: VA Heart of Texas Health Care Network in Arlington.[1] 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 VISN 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 areas of clinical and administrative operations:

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

The OIG conducted an unannounced virtual inspection of the VA Heart of Texas Health Care Network during the week of February 7, 2022. The OIG also inspected the following VISN 17 healthcare systems beginning the weeks of January 10 and February 7, 2022:

- Amarillo VA Health Care System (Texas)[2]
- Central Texas Veterans Health Care System (Temple)[3]
- El Paso VA Health Care System (Texas)
- South Texas Veterans Health Care System (San Antonio)[4]

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

[2] The Amarillo VA Health Care System's primary facility is the Thomas E. Creek VA Medical Center (Texas).

[3] The Central Texas Veterans Health Care System consists of the Doris Miller VA Medical Center (Waco) and the Olin E. Teague Veterans' Center (Temple).

[4] The South Texas Veterans Health Care System consists of the Audie L. Murphy Memorial Veterans' Hospital (San Antonio) and the Kerrville VA Medical Center.

- VA North Texas Health Care System (Dallas)[5]
- VA Texas Valley Coastal Bend Health Care System (Harlingen)
- West Texas VA Health Care System (Big Spring)[6]

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. The findings presented in this report give a snapshot of VISN 17 and facility performance within the identified focus area at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help VISN leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted an opportunity for improvement and issued one recommendation to the Chief Medical Officer in the Medical Staff Credentialing and Privileging review area. The result is detailed in the report section and summarized in appendix A on page 19.

Conclusion

The OIG issued one recommendation for improvement to the Chief Medical Officer. The number of recommendations should not be used as a gauge for the overall quality of care provided within this VISN. 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.

[5] The VA North Texas Health Care System consists of the Dallas and Garland VA Medical Centers and the Sam Rayburn Memorial Veterans Center (Bonham).

[6] The West Texas VA Health Care System's primary campus is the George H. O'Brien, Jr. VA Medical Center (Big Spring).

VA Comments

The Veterans Integrated Service Network Director agreed with the comprehensive healthcare inspection findings and recommendation and provided an acceptable improvement plan (see appendix C, page 21, and the response within the body of the report for the full text of the director's comments). The OIG will follow up on the planned actions for the open recommendation until they are completed.

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Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 17: VA Heart of Texas Health Care Network.[1] This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so they can make informed decisions to improve care.

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 credentialing and privileging
4. Environment of care
5. Mental health (focusing on suicide prevention)

[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), 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) 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The inspection team examined operations from May 22, 2017, through February 11, 2022, the last day of the unannounced multiday virtual inspection.[5] During the visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline. The OIG also performed inspections of the following VISN 17 healthcare systems beginning the weeks of January 10 and February 7, 2022:

- Amarillo VA Health Care System (HCS) (Texas)[6]
- Central Texas Veterans HCS (Temple)[7]
- El Paso VA HCS (Texas)
- South Texas Veterans HCS (San Antonio)[8]
- VA North Texas HCS (Dallas)[9]
- VA Texas Valley Coastal Bend HCS (Harlingen)
- West Texas VA HCS (Big Spring)[10]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[11] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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[5] The range represents the time from the previous comprehensive healthcare inspection of the South Texas Veterans HCS to the completion of the unannounced week-long virtual CHIP visit on February 11, 2022.

[6] The Amarillo VA HCS's primary facility is the Thomas E. Creek VA Medical Center (VAMC) (Texas).

[7] The Central Texas Veterans HCS consists of the Doris Miller VAMC (Waco) and the Olin E. Teague Veterans' Center (Temple).

[8] The South Texas Veterans HCS consists of the Audie L. Murphy Memorial Veterans' Hospital (San Antonio) and the Kerrville VAMC.

[9] The VA North Texas HCS consists of the Dallas and Garland VAMCs and the Sam Rayburn Memorial Veterans Center (Bonham).

[10] The West Texas VA HCS's primary campus is the George H. O'Brien, Jr. VAMC (Big Spring).

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

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.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[12] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their vision and strategy, and "practice systems thinking and collaboration across boundaries."[13] 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.[14]

To assess this VISN's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Access to care

Executive Leadership Position Stability and Engagement

The VISN is defined based on "VHA's [Veterans Health Administration's] natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics and other sites; contractual arrangements with private providers; sharing agreements and other government providers. The VISN is designed to be the basic budgetary and planning unit of the Veterans health care system."[15]

VISN 17 is an integrated healthcare delivery system that includes approximately 240,000 square miles in Texas and New Mexico. VISN 17 is comprised of medical facilities and outpatient clinics. According to data from the VA National Center for Veterans Analysis and Statistics, VISN 17 had a veteran population of 1,186,745 within its borders at the beginning of fiscal year

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

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

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

[15] The Curious Case of the VISN Takeover: Assessing VA's Governance Structure, Hearing Before the Committee on Veterans' Affairs U.S. House of Representatives, 115th Cong. (May 22, 2018) (statement of Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs).

(FY) 2022 and a projected FY 2023 population of 1,178,722.[16] The medical care budget was $3,880,425,705 for FY 2019; $5,242,751,775 for FY 2020; and $5,556,348,497 for FY 2021. This represents a two-year change of approximately 43 percent.

At the time of the OIG's visit, VISN 17 had an executive leadership team consisting of the Network Director, Deputy Network Director, and acting Chief Medical Officer (CMO). The CMO oversaw facility-level patient care programs.

To help assess VISN leaders' engagement, the OIG interviewed the Network Director, Deputy Network Director, acting CMO, and Quality Management Officer regarding their involvement and support of actions to improve or sustain performance.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[17] 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 VISN leaders.

The OIG reviewed VA's All Employee Survey satisfaction results from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal (see figure 2).[18]

[16] The OIG accessed these data on February 1, 2022.

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

[18] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders' All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

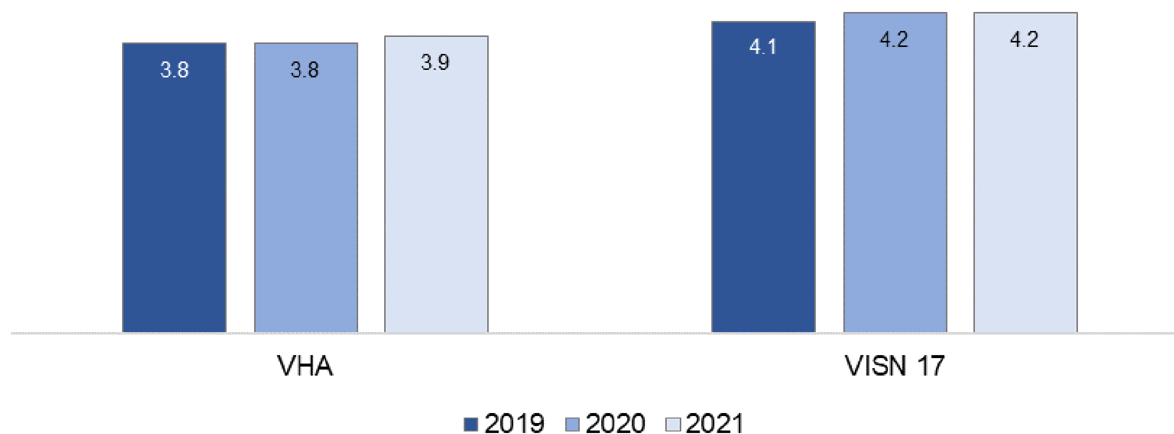

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed December 7, 2021).

Note: Respondents scored this survey item from 1 (Strongly Disagree) through 6 (Not applicable or Do not know).

Patient Experience

VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.[19]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[20] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the VISN from October 1, 2017 (FY 2018), through August 31, 2021 (FY 2021). Figures 3–5 provide relevant survey results for VHA and VISN 17.[21]

The VISN inpatient survey averages were lower than VHA averages but showed improvement each successive year. Scores for overall satisfaction with outpatient primary and specialty care were also lower than VHA averages. Leaders said that FY 2021 specialty care scores for several facilities, which had dropped below VHA averages, were likely associated with the COVID-19

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

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

[21] Scores are based on responses by patients who received care within the VISN.

pandemic and limited access to care in rural areas. To improve patient experiences, VISN leaders implemented a satisfaction initiative in which physicians sit and listen to patients' concerns for five minutes.

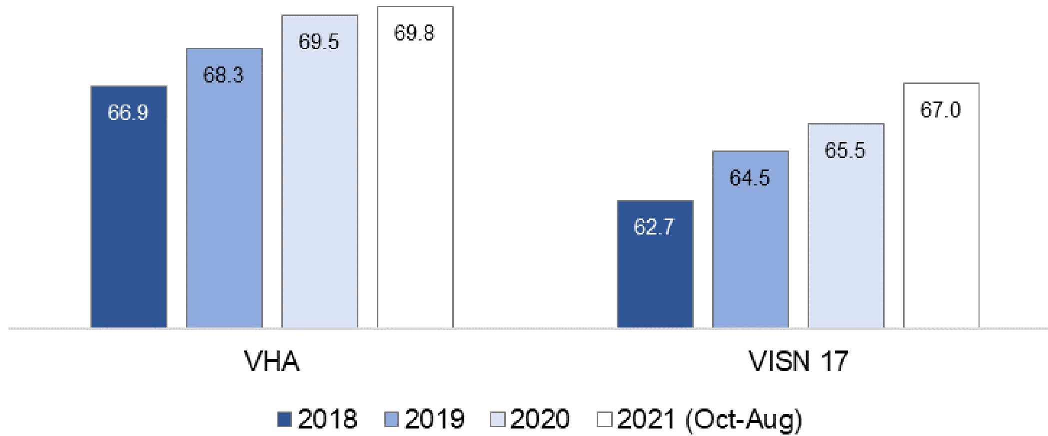

Figure 3. *Survey of Healthcare Experiences of Patients (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 2021).

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

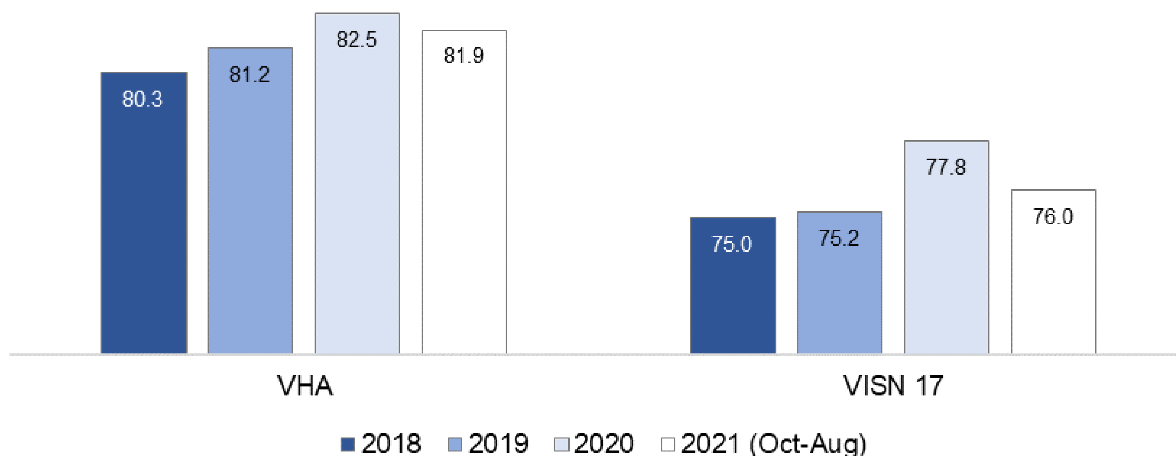

Figure 4. *Survey of Healthcare Experiences of Patients (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 2021).

Note: The response average is the percent of "Very Satisfied" and "Satisfied" responses.

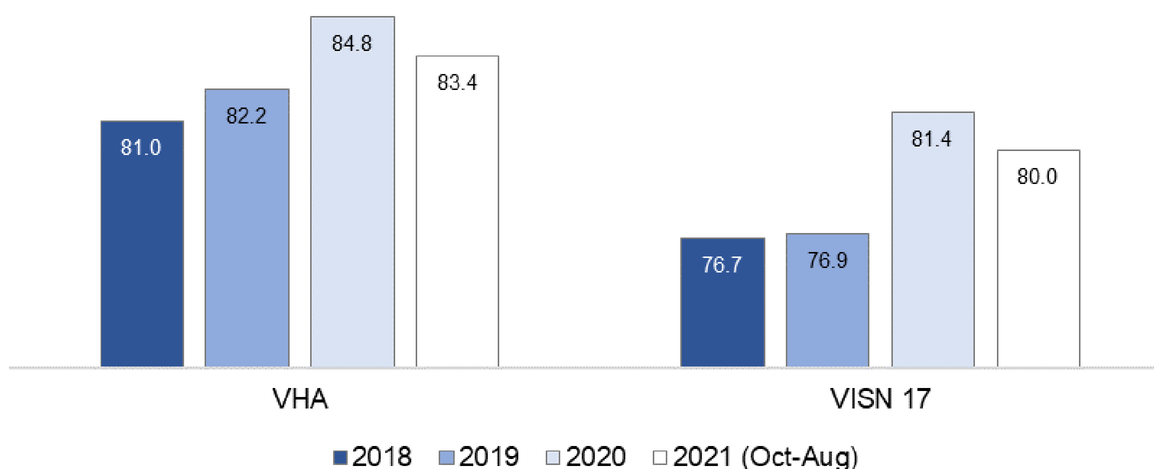

Figure 5. *Survey of Healthcare Experiences of Patients (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 29, 2021).

Note: The response average is the percent of "Very Satisfied" and "Satisfied" responses.

Access to Care

A VA priority is ensuring timely access to the best care and benefits for the nation's veterans. VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates. VHA's goal is to provide patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[22]

To examine access to primary and mental health care within VISN 17, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 1 and 2 provide wait time statistics for

[22] The "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity." VHA Directive 1230(5), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended September 24, 2021. (VHA rescinded and replaced this directive with VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.)

completed primary care and mental health appointments from July 1 through September 30, 2021.[23]

Table 1. Primary Care Appointment Wait Times (July 1 through September 30, 2021)

Facility	New Patient Appointments	Average New Patient Wait Times from Create Date (Days)
VISN 17	9,035	23.1
Amarillo VA HCS (TX)	404	21.1
Central Texas Veterans HCS (Temple)	1,970	28.2
El Paso VA HCS (TX)	551	32.9
South Texas Veterans HCS (San Antonio)	2,582	19.3
VA North Texas HCS (Dallas)	2,524	20.1
VA Texas Valley Coastal Bend HCS (Harlingen)	741	21.2
West Texas VA HCS (Big Spring)	263	25.0

Source: VHA Support Service Center (accessed December 8, 2021).

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

[23] Primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine. Mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual.

Table 2. Mental Health Appointment Wait Times (July 1 through September 30, 2021)

Facility	New Patient Appointments	Average New Patient Wait Times from Create Date (Days)
VISN 17	1,471	19.4
Amarillo VA HCS (TX)	80	13.6
Central Texas Veterans HCS (Temple)	678	15.9
El Paso VA HCS (TX)	129	29.9
South Texas Veterans HCS (San Antonio)	372	16.7
VA North Texas HCS (Dallas)	78	35.8
VA Texas Valley Coastal Bend HCS (Harlingen)	112	7.9
West Texas VA HCS (Big Spring)	22	6.4

Source: VHA Support Service Center (accessed December 8, 2021).

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

VISN leaders expressed concern about veteran patient population growth and its effect on care access. To help improve access to care in FY 2021, a VISN leader reported opening new clinics in Lubbock, northeast El Paso, and Tyler and continuing work on the VA Garland facility, with a projected 2023 opening date. Another leader said the VISN operated a clinical resource hub to provide gap coverage for facilities throughout the network in primary and mental health care.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[24] To meet this goal, VHA requires staff at its facilities to implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[25] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[26]

To determine whether VISN staff implemented OIG-identified key processes for quality and safety and incorporated them into their activities, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

[25] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs,* May 9, 2017. (VHA rescinded and replaced this directive with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

[26] VHA Directive 1100.16.

Medical Staff Credentialing and Privileging

The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with VHA policy," which includes the VISN CMO's oversight of credentialing and privileging processes at VISN facilities.[27] "Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system. Credentials are documented evidence of licensure, education, training, experience, or other qualifications."[28]

When certain actions are taken against a physician's licenses, the senior strategic business partner (previously known as the human resources officer) will make a recommendation to the VISN chief of human resources, who will then determine whether the physician meets licensure requirements for VA employment.[29] Further, the VISN CMO is required to document a review for any licensed independent practitioner with a history of licensure action such as a "license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application."[30] The VISN CMO must then "make a recommendation to the VHA medical facility that initiated the review process on the appropriateness of continuing the LIP's [licensed independent practitioner's] credentialing application or appointment at the facility."[31]

The OIG inspection team reviewed publicly available data and VetPro for VISN facility physicians hired after January 1, 2021, to determine whether leaders complied with clinical privileging requirements.[32] When reports from the National Practitioner Data Bank or Federation

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[27] 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.)

[28] VHA Directive 1100.20.

[29] VHA Directive 1100.20: Standard Operating Procedure – C25 version 3, *Mandatory Reviews of Adverse Licensure, Certification, or Registration Actions*, October 2, 2020. Providers are ineligible for VA appointment if they do not have a full unrestricted license, had a license revoked (without if being fully restored), or surrendered a license (in lieu of revocation). 38 U.S.C. § 7402.

[30] For this review, the OIG focused on physicians. A licensed independent practitioner "is any individual permitted by law...and the facility to provide patient care services independently, i.e., without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." VHA Handbook 1100.19; VHA Credentialing Directive 1100.20: Standard Operating Procedure – C40 version 2, *Conducting and Documenting a Chief Medical Officer Credentials Review*, November 9, 2020.

[31] VHA Credentialing Directive 1100.20: Standard Operating Procedure – C40 version 2.

[32] VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, focused on the approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards." VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file." VHA Handbook 1100.19.

of State Medical Boards appeared to confirm that a physician had a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

- VISN Chief Human Resources Officer's review to determine whether the physician satisfies VA licensure requirements, and
- VISN CMO's review and recommendation for any licensed independent practitioner with a specific licensure or malpractice history.[33]

Medical Staff Credentialing and Privileging Findings and Recommendations

VHA policy states the VISN CMO is required to document a review for any licensed independent practitioner with a history of a "license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application."[34] The VISN CMO must then "make a recommendation to the VHA medical facility that initiated the review process on the appropriateness of continuing with the LIP's [licensed independent practitioner's] credentialing application or appointment at the facility."[35] The OIG did not find evidence of the VISN CMO's review and recommendation for two physicians with potentially disqualifying licensure actions. In both cases, lack of the required review could have resulted in inappropriate hiring decisions that jeopardized the quality of patient care.

For one physician, the acting CMO reported discussing the findings with the Chief of Staff at the hiring facility and reviewing the VetPro documentation but being unable to find a review and recommendation by the previous CMO. For the second physician, the acting CMO reported the hiring facility's credentialing and privileging staff did not believe the LIP's adverse actions met the required triggers for referral to the VISN CMO.

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[33] VHA Directive 1100.20: Standard Operating Procedure – C25 version 3; VHA Credentialing Directive 1100.20: Standard Operating Procedure – C40 version 2. "The National Practitioner Data Bank (NPDB) is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers." "Health Workforce Data, Tools, and Dashboards," Health Resources & Services Administration, accessed August 24, 2022, https://data.hrsa.gov/topics/health-workforce/npdb. "The Federation of State Medical Boards represents the state medical and osteopathic regulatory boards – commonly referred to as state medical boards…[to] fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals." "About FSMB," Federation of State Medical Boards, accessed August 24, 2022, https://www.fsmb.org/about-fsmb/.

[34] VHA Handbook 1100.19.

[35] VHA Credentialing Directive 1100.20: Standard Operating Procedure – C40 version 2.

Recommendation 1

1. The Chief Medical Officer determines any additional reasons for noncompliance and reviews the credentials file and makes a recommendation on continuing the appointment process for physicians with a potentially disqualifying licensure action.

Veterans Integrated Service Network concurred.

Target date for completion: November 30, 2023

Veterans Integrated Service Network response: On February 10, 2022, the VISN 17 Credentialing & Privileging Officer (C&P) on behalf of acting CMO reminded all VISN 17 Chiefs of Staff, when to conduct and document Chief Medical Officer Reviews via email. February 9, 2022, VISN 17 C&P facility managers were reminded of the requirements for CMO review of history of licensure action or malpractice payment when one or more medical malpractice triggers are met. The VISN C&P Officer gave a presentation on CMO credentialing review requirements on February 14, 2022, at the VISN 17 Chiefs of Staff monthly call. A review was conducted of the Standard Operating Procedure titled Conducting and Documenting a Chief Officer Credential Review, at the VISN 17 Credentialing & Privileging Managers monthly meeting on February 10, 2022. The acting CMO also provided education on April 7, 2022, for VISN 17 Chiefs of Staff to ensure awareness of the process. A tracking tool was developed to monitor compliance for all VISN 17 facilities. The VISN 17 CMO reviews and documents recommendations in VetPro as required.

The Credentialing & Privileging Officer performed 100% audit of the Licensed Independent Practitioners (LIP) who met one or more medical malpractice triggers for FY 23 Q [quarter] 1 & 2, noted 100% compliance. FY 23 Q3 reviews in process. Outcomes of this action item will be reported monthly through the VISN 17 Quality Safety Value committee. Monitoring until at least 90% compliance is maintained for 6 consecutive months.

An audit form was developed to encompass the following fields:

a) Name of facility

b) LIP for FY 23 Malpractice and Adverse License Actions

c) CMO review of files if triggered

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires facility staff to provide a safe and clean environment of care for veterans, their families, visitors, and employees in accordance with applicable Joint Commission environment of care standards and federal regulatory, applicable VA, and VHA requirements. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[36]

To support these efforts, VHA requires VISNs to have a Comprehensive Environment of Care "oversight program with a charter."[37] VHA also mandates that VISN leaders ensure network facilities with acute inpatient mental health units submit their Mental Health Environment of Care Checklist review via the Patient Safety Assessment Tool every six months.[38]

The OIG inspection team reviewed relevant documents and interviewed VISN managers.

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[36] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021; VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[37] VHA Directive 1608.

[38] The Mental Health Environment of Care Checklist was designed to help facilities identify and address environmental risks for suicide and suicide attempts. The Patient Safety Assessment Tool is a web-based system used for staff to respond to deficiencies found on the Mental Health Environment of Care Checklist and track the implementation of corrective action plans. VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients,* May 12, 2017.

Mental Health: Suicide Prevention

Suicide prevention remains the top clinical priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides among U.S. adults."[39] Additionally, "among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019."[40]

VHA requires VISN leaders to appoint mental health staff to serve on the primary VISN governing body, participate on each state's suicide prevention council or workgroup, coordinate activities with state and local mental health systems and community providers, and serve as the VISN representative for the Suicide Prevention Program.[41]

The OIG reviewed relevant documents and interviewed managers to determine whether VISN staff complied with various suicide prevention requirements.

Mental Health Findings and Recommendations

The OIG made no recommendations.

[39] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

[40] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report.*

[41] VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015; VHA Directive 1160.07, *Suicide Prevention Program,* May 24, 2021.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care within this VISN, the OIG conducted a detailed review of five clinical and administrative areas and provided one recommendation on a systemic issue that may adversely affect patients. The recommendation does not reflect the overall caliber of services delivered within this VISN. However, the OIG's findings illuminate an area of concern, and the recommendation may help guide improvement efforts. The recommendation is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines one OIG recommendation aimed at reducing a vulnerability that may lead to patient safety issues or adverse events. The recommendation is attributable to the Chief Medical Officer. The intent is for this leader to use the recommendation to help improve operations and clinical care. The recommendation addresses an issue that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendation

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Credentialing and Privileging	• The Chief Medical Officer reviews the credentials file and makes a recommendation on continuing the appointment process for physicians with a potentially disqualifying licensure action.
Environment of Care	• None
Mental Health: Suicide Prevention	• None

Appendix B: VISN 17 Profile

The table below provides general background information for VISN 17.

Table B.1. Profile for VISN 17
(October 1, 2018, through September 30, 2021)

Profile Element	VISN Data FY 2019*	VISN Data FY 2020†	VISN Data FY 2021‡
Total medical care budget	$3,880,425,705	$5,242,751,775	$5,556,348,497
Number of: • Unique patients	438,399	441,152	464,594
• Outpatient visits	5,398,728	4,984,829	5,566,095
Unique employees§	15,868	16,812	17,451
Type and number of operating beds: • Community living center	770	772	772
• Domiciliary	593	608	549
• Hospital	692	709	692
Average daily census: • Community living center	738	570	400
• Domiciliary	513	274	143
• Hospital	415	391	446

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, 2018, through September 30, 2019.*
†October 1, 2019, through September 30, 2020.

‡October 1, 2020, through September 30, 2021.
§Unique employees involved in direct medical care (cost center 8200).

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 25, 2023

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Comprehensive Healthcare Inspection of Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network in Arlington

To: Director, Office of Healthcare Inspections (54CH04)

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

1. Thank you for the opportunity to respond to the Comprehensive Healthcare Inspection of the VISN 17 Heart of Texas Health Care Network in Arlington. VA remains committed to honoring our Nation's Veterans by ensuring a safe environment to deliver exceptional health care.
2. I agree with the action plan implemented by the VISN 17 Leadership team.

(Original signed by:)

Wendell E. Jones, MD
VISN 17 Network Director

OIG Contact and Staff Acknowledgments

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