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VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania

CHIP Report | 22-00071-216 | September 26, 2023

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Figure 1. *Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania.*

Source: https://www.va.gov/philadelphia-health-care/locations/.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
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 Corporal Michael J. Crescenz VA Medical Center and associated outpatient clinics in Pennsylvania and New Jersey. 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 emergency department and urgent care center suicide prevention initiatives)

The OIG conducted an unannounced inspection of the Corporal Michael J. Crescenz VA Medical Center during the week of June 6, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this medical center and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement and issued nine recommendations to the Director, Chief of Staff, and Associate Director for Patient/Nursing Services in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; and Environment of Care. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 30.

Conclusion

The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 33–34, 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

Abbreviations ii

Report Overview iii

Inspection Results iii

Purpose and Scope 1

Methodology 2

Results and Recommendations 3

Leadership and Organizational Risks 3

Quality, Safety, and Value 11

Recommendation 1 12

Medical Staff Privileging 14

Recommendation 2 15

Recommendation 3 17

Recommendation 4 18

Recommendation 5 18

Environment of Care 20

Recommendation 6 21

Recommendation 7 23

Recommendation 8 24

Recommendation 9 25

Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives....27

Report Conclusion....29

Appendix A: Comprehensive Healthcare Inspection Program Recommendations 30

Appendix B: Medical Center Profile 31

Appendix C: VISN Director Comments 33

Appendix D: Medical Center Director Comments 34

OIG Contact and Staff Acknowledgments 35

Report Distribution 36

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 Corporal Michael J. Crescenz VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so they can make informed decisions to improve care.[1]

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

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

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on emergency department and urgent care center 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), 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 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

Methodology

The Corporal Michael J. Crescenz VA Medical Center includes associated outpatient clinics in Pennsylvania and New Jersey. General information about the medical center can be found in appendix B.

The inspection team examined operations from February 25, 2019, through June 10, 2022, the last day of the unannounced multiday evaluation.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until medical center leaders complete corrective actions. The 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 completed its last comprehensive healthcare inspection of the Corporal Michael J. Crescenz VA Medical Center in March 2019. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in September 2020.

[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 vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this medical center's leadership and risks, the OIG considered several indicators:

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Director, Deputy Director, Chief of Staff, Associate Director for Patient/Nursing Services, Associate Director, and Assistant Director/Eastern Market Manager (Assistant Director). The Chief of Staff and Associate Director for Patient/Nursing Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the Director had served in the role since 2019, the Chief of Staff since 2017, and the Associate Director for Patient/Nursing Services since 2014. The Deputy Director was assigned the role in 2015; however, the permanent staff member was temporarily assigned to another VISN, and an acting Deputy Director was in place at the time of the OIG review. The Associate and Assistant Directors had both been in their roles less than two years.

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

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

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

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2021 annual medical care budget of $751,960,152 had increased almost 15 percent compared to the previous year's budget of $655,618,886.[10] The Director stated leaders spent the budgetary increase on outpatient community care and staff hiring during the COVID-19 pandemic, including providers and Emergency Management Services contracts and personnel.[11] The acting Deputy Director discussed the increased community care funds, stating patients have the right to seek care in the community.

Employee Satisfaction

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

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal (see figure 2).[13]

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

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

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

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

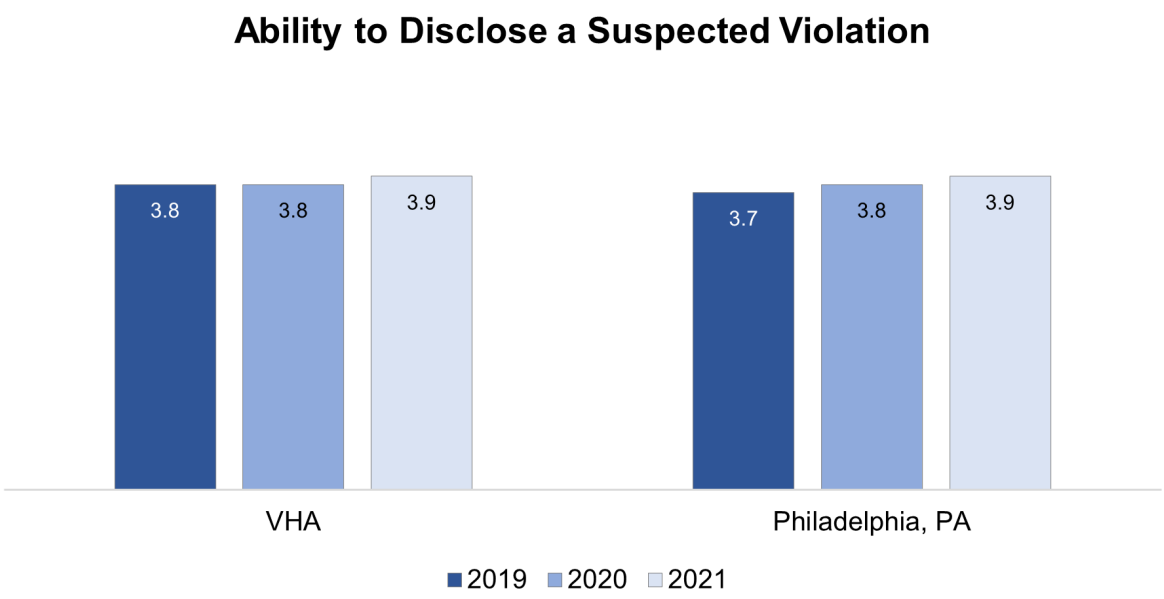

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed May 4, 2022).

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

Patient Experience

Veterans Health Administration (VHA) uses 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.[14]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the medical center over time.[16]

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

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

[16] Scores are based on responses by patients who received care at this medical center.

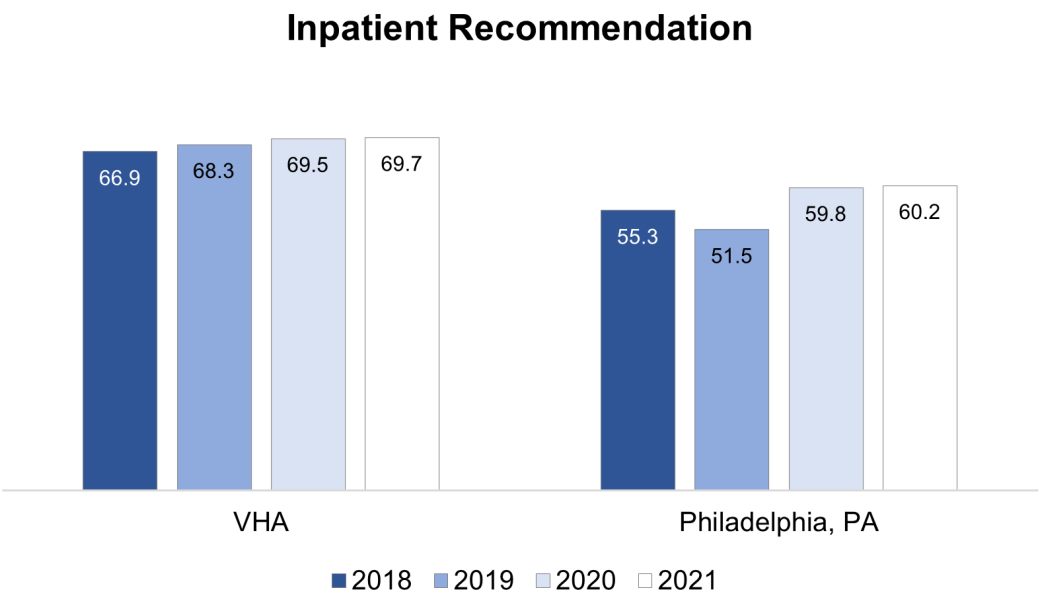

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

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

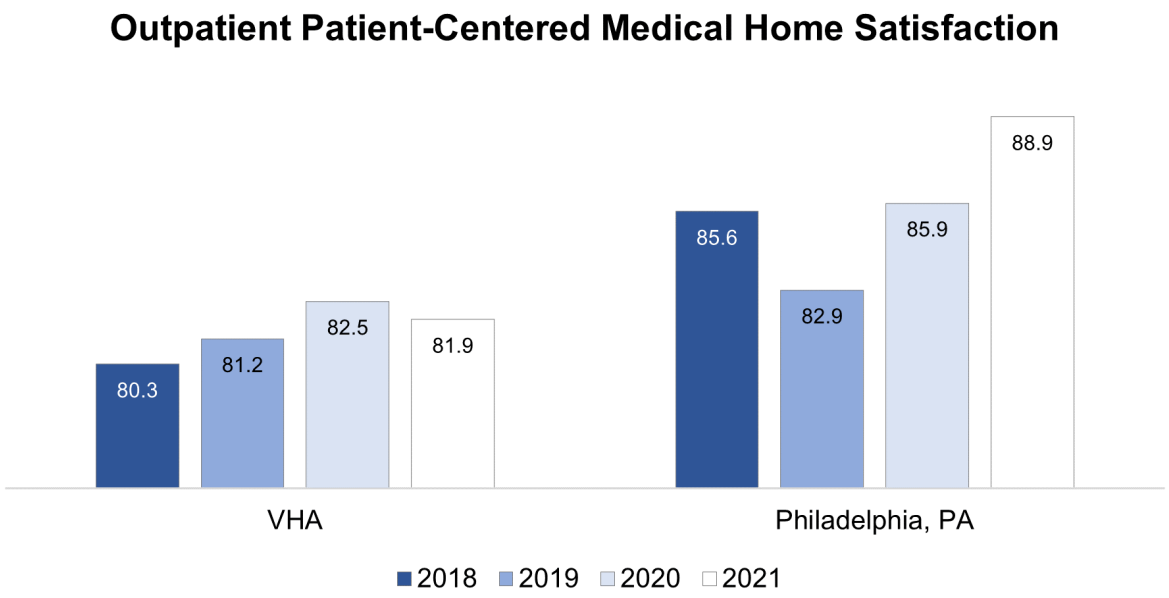

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

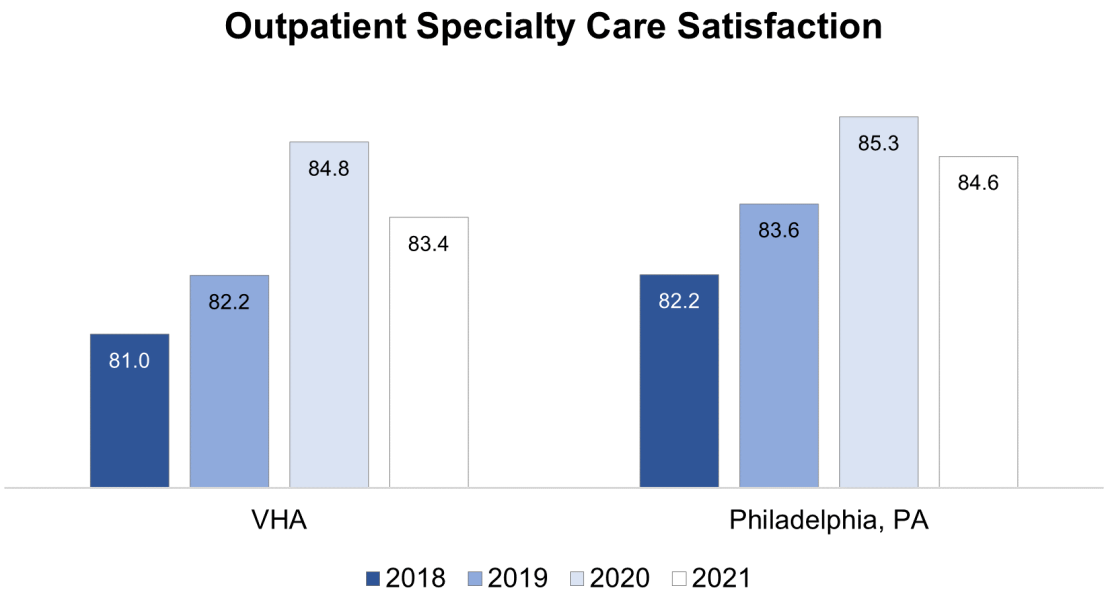

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of "Very satisfied" and "Satisfied" responses.

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] "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

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

[18] The Joint Commission, *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.

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.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[21] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[22]

The OIG requested sentinel events and institutional and large-scale disclosures that occurred from February 25, 2019, through June 6, 2022, and reviewed the information staff provided. The Director reported being notified immediately by the chief of the quality management department when adverse events occurred; the executive leadership team then reviewed them to determine follow-up actions such as a root cause analysis or reporting to The Joint Commission.[23] The Chief of Staff explained that when staff notify leaders about adverse events with a safety assessment code score of 3, they conduct an executive-level review, discussing the events and recommendations for next steps.[24]

The OIG identified an organizational risk factor related to staff conducting root cause analyses for adverse events with a safety assessment code score of 3. This will be discussed further in the Quality, Safety, and Value section. The Chief of Staff stated that although an executive-level review of these adverse events occurred, leaders did not clearly communicate case dispositions. The Director was aware of the events and told the OIG that enhanced communication to improve the review process was a priority. The Director also stated the executive leaders reviewed

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

[20] VHA Directive 1004.08.

[21] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

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

[23] A root cause analysis is a focused review to identify the actual system- and process-related contributing factors of the event. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

[24] Adverse events and close calls are assigned a safety assessment code score based on the severity of the event and how often it occurs. The safety assessment code score is ranked as 3 = highest risk, 2 = intermediate risk, 1 = lowest risk. VHA Handbook 1050.01. VHA Directive 1050.01 contains similar language to define safety assessment code scores.

adverse events each morning and revised the review process in mid-February 2022 to include the safety assessment code score.

Leadership and Organizational Risks Findings and Recommendations

The OIG issued a recommendation related to adverse patient safety events in the Quality, Safety, and Value section. The OIG made no additional recommendations.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[25] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[26] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[27]

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the medical center's committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the medical center's processes for conducting peer reviews of clinical care.[28] 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."[29] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[30]

Finally, the OIG assessed the medical center's culture of safety.[31] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

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

[26] 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.)

[27] VHA Directive 1100.16.

[28] 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.

[29] VHA Directive 1190.

[30] VHA Directive 1190.

[31] 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, accessed October 3, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, peer reviews with a final level of 3, patient safety reports, and other relevant information.[32]

Quality, Safety, and Value Findings and Recommendations

VHA requires staff to complete an individual root cause analysis for all events assigned an actual or potential safety assessment code score of 3.[33] The OIG found that for events with an actual or potential safety assessment code score of 3 that occurred from May 1, 2021, through April 30, 2022, staff did not consistently complete an individual root cause analysis. When leaders do not thoroughly review a patient safety event, it may limit their awareness of system vulnerabilities that could lead to patient harm. The Chief of Staff and Associate Chief of Staff explained that after clinical- and executive-level reviews of the events with a safety assessment code score of 3, leaders determined that none needed a root cause analysis. The Director said there should have been clearer communication with patient safety managers after the executive-level reviews.

Recommendation 1

1. The Director evaluates and determines any additional reasons for noncompliance and ensures staff complete an individual root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.

[32] A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently." VHA Directive 1190.

[33] VHA Handbook 1050.01; VHA Directive 1050.01.

Medical center concurred.

Target date for completion: September 21, 2023

Medical center response: The Medical Center Director (MCD) reviewed the recommendations and did not identify any additional reason for noncompliance. Patient Safety Managers (PSM) implemented a process to ensure that a root cause analysis (RCA) or an aggregated review is conducted for all patient safety events assigned an actual or potential safety assessment code (SAC) score of "3" per VHA Directive 1050.1. Monitoring of this process began in September 2022.

The numerator (N) was number of Joint Patient Safety Reports (JPSR) with an actual or potential SAC of 3 that received an RCA or were included in an aggregated review. The denominator (D) was the number of JPSR with an actual or potential SAC of 3. Goal was set at 100% compliance for 6 consecutive months. We achieved our goal at 6 months and continued to monitor to ensure sustainment through July 2023. N: 22, D: 22 = 100% for 11 consecutive months. Evidence of standards met was reported via Executive Leadership Team (ELT) JPSR monthly meeting via ELT JPSR reports and audits from JPSR system of Events with Actual or Potential SAC of 3 Reports. Compliance will be reported to the next Quality Executive Board (QEB) on September 21, 2023.

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."[34] 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."[35]

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.[36] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[37]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE process occurs when a practitioner 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.[38]

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.[39] 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 and aligned under the chief of staff. VHA also requires facilities to have credentialing

[34] 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.)

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[40]

The OIG interviewed key managers and reviewed the privileging folders of 30 medical staff members who had an FPPE or OPPE.

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to incorporate service-specific criteria in OPPEs and use these criteria for the ongoing monitoring of LIPs' clinical practices.[41] For the LIPs' OPPEs reviewed, the OIG found that service chiefs did not consistently incorporate service-specific criteria. When service chiefs' evaluations lack relevant criteria to support recommendations to continue privileges, it may negatively affect the delivery of quality patient care. The Chief of Staff reported that another similarly trained and privileged provider evaluated each LIPs' patient care and procedure skills by reviewing documentation within the specialty.

Recommendation 2

2. The Chief of Staff determines the reasons for noncompliance and ensures service chiefs incorporate service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.

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

[41] VHA Handbook 1100.19; VHA Directive 1100.21(1). For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

Medical center concurred.

Target date for completion: February 29, 2024

Medical center response: The Chief of Staff (COS) reviewed the recommendations and did not identify any additional reason for noncompliance. Since January of 2022, the facility utilizes approved service-specific national clinical indicators during Licensed Independent Practitioners (LIPs) chart reviews for all specialties. These service-specific national clinical indicators contribute to the Ongoing Professional Practice Evaluation (OPPE) data. The Credentialing and Privileging Program Analyst will conduct monthly monitoring of provider OPPE data.

The numerator will be the number of OPPEs conducted utilizing the national service-specific clinical criteria. The denominator will be the total number of OPPEs sent for review. The Credentialing and Privileging Program Manager will present the compliance results to the Medical Executive Board (MEB), of which the Chief of Staff chairs. Compliance will be tracked through the MEB until the goal of 90% compliance is achieved and sustained for 6 consecutive months.

VHA requires that, at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific OPPE data when recommending the continuation of LIPs' privileges to an executive committee of the medical staff. These data are maintained as part of the LIP's profile and may include direct observation, clinical discussions with other members of the care team, and review of diagnoses and treatments.[42] For the 20 LIPs' privileging folders reviewed, the OIG found that not all contained evidence service chiefs recommended continuation of privileges based, in part, on OPPE data. This resulted in LIPs continuing to deliver care without a thorough review of their practice, which could negatively affect safe patient care.

The Chief of Staff reported that one LIP only had one telephone encounter and no additional patient contacts during the period of review; therefore, evaluators could not complete the required chart reviews. The Chief of Staff added that the abrupt departure of a prior section chief resulted in missing OPPE data for another LIP. For another LIP, the Chief of Staff reported waiving some OPPE requirements per VA guidance during the COVID-19 pandemic; however, the Chief of Staff did not provide the OIG the medical center's justification, and the Credentialing and Privileging Committee and Medical Executive Board's meeting minutes did not contain a discussion of the decision.[43] The Chief of Staff reported allowing the service chiefs the autonomy to decide whether to use the previous requirements or those described in the

[42] VHA Handbook 1100.19; VHA Directive 1100.21(1). The executive committee of the medical staff was referred to as the Medical Executive Board at this medical center.

[43] Deputy Under Secretary for Health for Organizational Excellence memo, "FPPE and OPPE Process during Presidential Declared State of Emergency – COVID-19," April 3, 2020.

pandemic guidance for OPPEs. The Chief of Staff also reported believing most service chiefs had continued following the traditional process and completed OPPEs timely.

Recommendation 3

3. The Chief of Staff evaluates and determines additional reasons for noncompliance and ensures service chiefs recommend reprivileging based, in part, on Ongoing Professional Practice Evaluation data.

Medical center concurred.

Target date for completion: February 29, 2024

Medical center response: The Chief of Staff (COS) reviewed the recommendations and did not identify any additional reason for noncompliance. The Corporal Michael J Crescenz VAMC [VA Medical Center] updated all Ongoing Professional Practice Evaluation (OPPE) Chart Review Forms in January of 2022 to comply with the VHA Mandated Implementation of Enterprise-Wide OPPE Specialty Specific Clinical Indicators.

The Credentialing and Privileging Program Analyst will conduct audits to ensure that documentation indicated the Service Chief's recommendation of pertinent options is based, in part, on OPPE activities.

The numerator will be the number of OPPE forms with evidence of the Service Chief's determination to recommend continuation of current privileges, which was based in part on OPPE activities. The denominator will be the total number of OPPEs forms reviewed. The Credentialing and Privileging Program Manager will present the compliance results to the Medical Executive Board (MEB), of which the Chief of Staff chairs. Compliance will be tracked through the MEB until the goal of 90% compliance is achieved and sustained for 6 consecutive months.

VHA requires service chiefs to document FPPE results and report them to an executive committee of the medical staff. When a practitioner is reprivileged, VHA requires an executive committee of the medical staff to review service chiefs' recommendation and OPPE results and document its review when making reprivileging recommendations to the director.[44] The OIG did not find evidence service chiefs consistently reported LIPs' FPPE results to the Medical Executive Board. The OIG further noted that for some LIPs reprivileged, the Director approved the privileges before the Medical Executive Board documented its review of the OPPE results. Failure to properly review evaluation results or document recommendations may result in incomplete evidence to support the Director's approval of clinical privileges.

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

The Chief of Staff reported believing clerical errors resulted in the LIPs' FPPE results not being documented in the Medical Executive Board's meeting minutes. Additionally, the VISN 4 Credentialing and Privileging Officer (who had been the facility's most recent Credentialing and Privileging Manager and was still covering the role while the position was vacant) reported the Director approved LIPs for reprivileging prior to the board's review to not disrupt patient care, but the board then reviewed the results at its next scheduled meeting.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs report Focused Professional Practice Evaluation results to the Medical Executive Board.

Medical center concurred.

Target date for completion: February 29, 2024

Medical center response: The Chief of Staff (COS) reviewed the recommendations and did not identify any additional reason for noncompliance. The Credentialing and Privileging Program Analyst will conduct monthly monitoring of providers on Focused Professional Practice Evaluation (FPPE).

The numerator will be the number of FPPE forms submitted to the Medical Executive Board (MEB) for review/conclusion/continuation. The denominator will be the total number of FPPE forms due that month. The Credentialing and Privileging Program Manager will present the compliance results to the Medical Executive Board (MEB), of which the Chief of Staff chairs. Compliance will be tracked through the MEB until the goal of 90% compliance is achieved and sustained for 6 consecutive months.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Medical Executive Board reviews Ongoing Professional Practice Evaluation results and documents its review when making reprivileging recommendations to the Director.

Medical center concurred.

Target date for completion: March 31, 2024

Medical center response: The Chief of Staff (COS) reviewed the recommendations and did not identify any additional reason for noncompliance. The Corporal Michael J Crescenz VAMC updated all Ongoing Professional Practice Evaluation (OPPE) Chart Review Forms in January of 2022 to comply with the VHA Mandated Implementation of Enterprise-Wide Ongoing Professional Practice Evaluation (OPPE) Specialty Specific Clinical Indicators. The Corporal Michael J Crescenz VAMC will utilize OPPE summary forms, which incorporate measurements of competency to include a formatted area in which the Service Chief recommends the options of continuing OPPE/privileges, or initiating a plan for performance improvement, recommend limiting clinical privileges/scope of practice, or recommendation to revoke clinical privileges/scope of practice as part of the overall evaluation of OPPE results.

The Credentialing and Privileging Program Analyst conducts audits to ensure that documentation indicated the Service Chief's recommendation of pertinent options, such as privileges are continued, identified performance improvement areas, limited or revoked privileges, are based, in part, on OPPE activities.

The numerator will be the number of Licensed Independent Provider's (LIPs) privileging decisions that reflect evidence of discussion of the OPPE process. The denominator will be the number of LIPs' privileging decisions. The Credentialing and Privileging Program Manager will present the compliance results to the Medical Executive Board (MEB), of which the Chief of Staff chairs. Compliance will be tracked through the MEB until the goal of 90% compliance is achieved and sustained for 6 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 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.[45] The physical environment of a healthcare organization must not only be functional but should also promote healing.

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 assessed compliance in 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.[46]

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.[47] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times in emergencies and contribute to a safe healthcare environment.[48]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected five patient care areas:[49]

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[45] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded and replaced this directive with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.)

[46] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

[47] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[48] Opioids are medications that are "effective at reducing pain" but "when taken in excess, can lead to respiratory arrest." Naloxone "is a highly effective treatment for reversing an opioid overdose." "Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit," VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, "Automated External Defibrillators (AEDs)," accessed December 16, 2021, https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds. "Pharmacy Benefits Management Services," Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

[49] The OIG did not inspect the community living center because it had COVID-19-positive patients.

- Emergency Department
- Inpatient mental health unit (7 West)
- Medical/surgical inpatient unit (6 East)
- Specialty care clinic (urology)
- Surgical Intensive Care Unit

Environment of Care Findings and Recommendations

VHA requires facilities to have a comprehensive environment of care program, which includes staff conducting environment of care 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."[50] The OIG reviewed records of the completed FY 2021 environment of care inspections and found staff did not inspect some clinical care areas at the required frequency.[51] Not inspecting clinical areas on a routine schedule can lead to an unsafe environment for patients, visitors, and staff. The Interim Safety Manager, who had started in February 2022, was not present in FY 2021 and therefore unable to explain why staff did not complete the inspections but reported believing staff inspected the areas as required.

Recommendation 6

6. The Director determines the reasons for noncompliance and ensures staff conduct environment of care inspections at the required frequency.

[50] VHA Directive 1608.

[51] The OIG found no evidence staff conducted the required number of inspections in FY 2021 in the following clinical areas: Physical Therapy, Rehabilitation, Psychiatry (Inpatient Mental Health Unit) on the seventh floor-West, Neurology, Cardiac Catheterization Lab, areas on the fifth and seventh floors, Surgical Intensive Care Unit, Short Procedure Unit, Surgery Clinics, Radiology, and the Fort Dix community-based outpatient clinic.

Medical center concurred.

Target date for completion: September 19, 2023

Medical Center response: The Medical Center Director (MCD) reviewed the recommendations and did not identify any additional reason for noncompliance. Significant improvements have been made to the Comprehensive Environment of Care Program (CEOC) per VHA Directive 1608. New inspectors have been identified and trained, as well as back-up staff, to ensure all required rounds are conducted and documented into the Performance Logic portal. The Chief of Facilities Management (FMS) made EOC Rounds one of their FY23 goals for improvement. The EOC rounds were tracked to ensure all required areas for that month were inspected. Our cumulative goal was set at 90% or above. Numerator: # of areas inspected; Denominator: # of areas required to be inspected in that month (N: 58, D: 58 = 100%). Compliance goal has been achieved and sustained as of July 2023 for the previous twelve (12) months. Compliance will be reported to the next monthly Environment of Care (EOC) Committee on September 19, 2023.

VHA requires directors to follow Joint Commission standards for staff to monitor environmental conditions to ensure a clean and safe environment, which includes not storing corrugated boxes in patient care areas.[52] For the clinical areas inspected, the OIG observed dirty and dusty patient rooms and supply closets, dirt and dust above and below eye level in medication rooms, ice and water machines with dirty dispensing tubes, damaged walls, chipped paint, taped signage and information on the walls, stained and damaged ceiling tiles, corrugated boxes and employee belongings in patient care areas, sharps containers unsecured and on the floor, and a tube system used for both specimens and medications with no process to prevent cross contamination.[53] Not maintaining a safe and clean clinical environment could result in injury or illness of patients, visitors, and staff.

The Chief of Environmental Management Services reported being unaware Environmental Management Services staff were not getting access to locked areas for cleaning and believing

[52] VHA Directive 1608; VHA Directive 1100.16; The Joint Commission, *Standards Manual,* E-dition, EC.02.06.01, January 2020. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020. Corrugated boxes are an infection control concern because they can house pests and bacteria. "What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers," The Joint Commission, accessed August 2, 2023, https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/infection-prevention-and-control-ic/000002145/.

[53] All five units inspected had damaged walls, including some with holes, damaged or stained ceiling tiles in common areas, and four units had chipped paint. The medical/surgical unit had stained and damaged ceiling tiles, corrugated boxes, employee personal items stored in a patient care area, and a sharps container (used to dispose of sharp medical instruments such as needles) on the floor. The mental health unit had dirty patient rooms, corrugated boxes, signage taped to walls, and dirt and dust in the medication room. The Emergency Department had corrugated boxes, employee personal items stored in a patient care area, and signage taped to walls. The Surgical Intensive Care Unit had a sharps container unsecured, a tube system (used to transport items between areas) for both specimens and medications housed in a supply closet, and dust in a medication room.

staff were cleaning the ice and water machines as required. The Chief of Facilities Management Services attributed noncompliance to staffing challenges, competing priorities from in-house construction projects, and staff being unaware of the work order process. The Carpenter Supervisor stated the most recent ceiling tile order had been delayed. Nurse managers cited a lack of attention to detail. The Assistant Nurse Manager and Chief of Environmental Management Services acknowledged that lack of oversight led to the placement of the sharps containers on the floor. The Chief of Staff reported being unaware the tube system canisters were used for both specimens and medications.

Recommendation 7

7. The Director determines any additional reasons for noncompliance and ensures staff maintain a clean and safe environment.

Medical center concurred.

Target date for completion: February 29, 2024

Medical center response: The Medical Center Director (MCD) reviewed the recommendations and did not identify any additional reason for noncompliance. Nine of the ten Environment of Care deficiencies identified in clinical areas were corrected and monitored to compliance with the exception of the sharps containers. The areas were monitored for at least six months by Service points of contact. The goal set was 90% compliance and achieved in February 2023.

Patient Care Services Audited (1) Personal belongings; (2) Taped Signage; (3) Ice Machines; (4) Corrugated shipping boxes; (5) Transport tubes; and (6) Damaged walls, chipped paint, and ceiling tiles utilizing one comprehensive tracer. August N: 114, D: 120; September N: 123, D: 130; October N: 110, D: 114; November D[N]: 104, D: 111; December N: 93, D: 96; January 2023 N: 92, D: 96. (Total Audit results for 6 consecutive months - N: 636, D: 667 = 95%).

Environmental Services conducted 3 separate audits. (1) Dirty supply closets - August N: 19, D: 19; September N: 18, D: 18; October N: 16, D: 16; November N: 12, D: 13; December N: 10, D: 10; January 2023 N: 9, D: 9. (Total Audit results for 6 consecutive months - N: 84, D: 85 = 98%). (2) Dirty patient rooms - August N: 10, D: 10; September N: 5, D: 5; October N: 8, D: 8; November N: 17, D: 17; December N: 7, D: 7; January 2023 N: 5, D: 5. Total Audit results for 6 consecutive months - N: 52, D: 52= 100%). (3) Dirty medication rooms - August (data collection not started); September N: 9, D: 9; October N: 15, D: 15; November N: 23, D: 23; December N: 9, D: 9; January 2023 N: 11, D: 11; February 2023 N: 9, D: 9. (Total Audit results for 6 consecutive months - N: 76 D: 76 = 100%).

Compliance will be reported to the Environment of Care Committee on September 19, 2023, and the Quality Executive Board (QEB) on September 21, 2023.

It was identified by the Chief of Environmental Management Services (EMS) that the contractor responsible for picking up and replacing sharps containers was no longer fulfilling their obligations. This led to sharps containers being left full and incorrect types and sizes of containers being brought to clinical areas. The Chief of EMS addressed the deficiencies with the contractor and ensured that our contract requirements were being met. In addition, a workgroup was established by Quality Management and Nurse Managers. Walk-through assessments were conducted to determine the appropriate types of sharps containers required for each clinical areas, based on the workflow. Appropriate wire frames (with foot pedal for safety and locks) for the large floor model containers were ordered and deployed. EMS Supervisor will conduct weekly rounds in those areas to ensure they are secured in frames, and none are left on the floor, as well as random monthly rounds in clinical areas to ensure wall mounted sharps containers are secure and not overflowing. Our goal is >90% for 6 consecutive months, starting August 2023. Numerator: # of sharps containers present, properly secured, and not overflowing. Denominator: # of sharps containers required and observed. Chief of EMS or designee will report the data results to the Sharps Committee and the EOC Committee until compliance goal is achieved.

VHA requires inpatient mental health staff to ensure a "safe, therapeutic, and healing environment" of care.[54] On the inpatient mental health unit, the OIG observed a television cabinet with a gap in the plexiglass in the day room and an open and unlocked box in the dining room which allowed access to electrical cords that could be used as possible ligature points.[55] Failure to address environmental safety concerns in the inpatient mental health unit could result in patient, visitor, or staff injury. The Nurse Manager stated the box was for storing digital media and was unlocked because staff did not have a key. After OIG identified the concern, the Carpenter Supervisor provided staff with a key to the box.

Recommendation 8

8. The Director determines any additional reasons for noncompliance and ensures staff maintain a safe environment in the inpatient mental health unit.

[54] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

[55] "A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation." "Clarification of Ligature Risk Policy," Centers for Medicare and Medicaid Services, accessed August 2, 2023, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-18-06.

Medical center concurred.

Target date for completion: September 21, 2023

Medical center response: The Medical Center Director (MCD) reviewed the recommendations and did not identify any additional reason for noncompliance. The Nurse Manager ensured that the gap in the plexiglass behind the TV box was repaired on the day of inspection. Keys were provided to the staff so that they could lock the TV DVD storage box to ensure cords are not exposed. The Nurse Manager modified the current Environment of Care checklist to include the TV DVD box to ensure no cords were exposed and it was locked. Numerator: # of times TV DVD box secured with no cords exposed. Denominator: # of TV DVD box observations. Due to ligature risk potential, the goal was set at 100% compliance for 6 consecutive months. Tracers were conducted at random day[s]/times on the Behavioral Health Unit from August 2022 through February 2023.

August N: 19, D: 19; September N: 66, D: 66; October N: 49, D: 49; November D[N]: 37, D: 37; December N: 36, D: 36; January 2023 D[N]: 34, D: 34; February 2023 N: 49, D: 49. (Total Audit results for 7 consecutive months - N: 290, D: 290 = 100%).

Compliance will be reported to the next Quality Executive Board (QEB) on September 21, 2023.

VHA also requires medications and supplies to be stored in a secure manner with access limited to authorized personnel.[56] The OIG observed one location with medication and supply room access codes written on the walls next to the entrances and an unlocked medication refrigerator. Since the access codes were displayed, unauthorized personnel had access to the medication and supply rooms. Removal of safety barriers can result in increased risk and opportunity for unauthorized staff to remove medications and supplies for personal use or to cause harm.[57] The Associate Chief of Nursing Services for Ambulatory Care acknowledged being unaware the access code was written on or near the medication room door.

Recommendation 9

9. The Associate Director for Patient/Nursing Services determines the reasons for noncompliance and ensures only authorized personnel have access to medication and supply rooms.

[56] VHA Directive 1108.06(2) *Inpatient Pharmacy Services*, February 8, 2017, amended August 26, 2021. (VHA rescinded and replaced this directive with VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022.) VHA Directive 1761.

[57] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

Medical center concurred.

Target date for completion: September 21, 2023

Medical center response: The Associate Director for Patient/Nursing Services reviewed the recommendations and did not identify any additional reason for noncompliance. The Accreditation Specialist in collaboration with the Nurse Managers modified our current Survey Readiness Tracer to include checking the medication rooms to ensure only licensed personnel were accessing, as well as to ensure the key-pad code was not written on door jambs or visible near the medication room. Random tracers were conducted on the medical surgical and intensive care units from August 2022 through February 2023. Numerator : # of observations where medication room secure with no unlicensed personnel or key-pad codes visible. Denominator: # of medication room observations. Our goal was set at 90% or greater for 6 consecutive months.

August N: 18, D: 18; September N: 19, D: 19; October N: 19, D: 19; November N: 19, D: 19; December N: 20, D: 20; January 2023 N: 19, D: 19; February 2023 N: 20, D: 20. (Total Audit results for 7 consecutive months - N: 134, D: 134 = 100%).

Compliance will be reported to the Quality Executive Board (QEB) on September 21, 2023.

Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives

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."[58] 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."[59]

VHA implemented various evidence-based approaches to reduce veteran suicides, including 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.[60] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from emergency departments or urgent care centers and receive "structured post-discharge follow-up to facilitate engagement in outpatient mental health care."[61] The OIG assessed the medical center for its adherence to staff completion of suicide safety plans prior to patients' discharge from the Emergency Department or urgent care center and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and staff and reviewed the electronic health records of 49 randomly selected patients who were seen in the Emergency Department from December 31, 2020, through August 1, 2021.

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

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

[60] 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.)

[61] Deputy Under Secretary for Health for Operations and Management memo, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives," October 17, 2019. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions," October 1, 2021.)

Mental Health Findings and Recommendations

The OIG made no recommendations.

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 at their medical center, the OIG conducted a detailed review of five clinical and administrative areas and issued nine recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this medical center. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines nine OIG recommendations aimed at reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and Associate Director for Patient/Nursing Services. The intent is for leaders to use recommendations as a road map to help improve 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	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• Staff complete an individual root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.
Medical Staff Privileging	• Service chiefs incorporate service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners. • Service chiefs recommend reprivileging based, in part, on Ongoing Professional Practice Evaluation data. • Service chiefs report Focused Professional Practice Evaluation results to the Medical Executive Board. • The Medical Executive Board reviews Ongoing Professional Practice Evaluation results and documents its review when making reprivileging recommendations to the Director.
Environment of Care	• Staff conduct environment of care inspections at the required frequency. • Staff maintain a clean and safe environment. • Staff maintain a safe environment in the inpatient mental health unit. • Only authorized personnel have access to medication and supply rooms.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• None

Appendix B: Medical Center Profile

The table below provides general background information for this high complexity (1b) affiliated medical center reporting to VISN 4.[1]

Table B.1. Profile for Corporal Michael J. Crescenz VA Medical Center (642) (October 1, 2018, through September 30, 2021)

Profile Element	Medical Center Data FY 2019*	Medical Center Data FY 2020†	Medical Center Data FY 2021‡
Total medical care budget	$588,905,377	$655,618,886	$751,960,152
Number of:			
• Unique patients	59,940	57,310	63,625
• Outpatient visits	657,398	611,418	706,337
• Unique employees§	2,343	2,401	2,515
Type and number of operating beds:			
• Community living center	240	240	240
• Domiciliary	40	40	40
• Medicine	59	59	59
• Mental health	39	39	39
• Rehabilitation medicine	10	10	10
• Surgery	33	33	33
Average daily census:			
• Community living center	91	85	72
• Domiciliary	29	17	13
• Medicine	37	37	39
• Mental health	26	19	19
• Rehabilitation medicine	3	3	2

[1] VHA medical facilities are classified according to a complexity model; a designation of "1b" indicates a facility with "medium-high volume, high-risk patients, many complex clinical programs, and medium-large sized research and teaching programs." "VHA Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2019*	Medical Center Data FY 2020†	Medical Center Data FY 2021‡
Average daily census (cont.):			
• Surgery	13	11	14

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: September 6, 2023

From: Director, VISN 4: VA Healthcare (10N4)

Subj: Comprehensive Healthcare Inspection of the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania

To: Director, Office of Healthcare Inspections (54CH03)

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

1. Thank you for the opportunity to review the draft report, Comprehensive Healthcare Inspection of the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania.
2. I have reviewed the recommendations in the OIG draft report. I concur with the recommendations and action plans submitted by the Corporal Michael J. Crescenz VA Medical Center.

(Original signed by:)

Timothy W. Liezert
Network Director, VISN 4

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: September 6, 2023

From: Director, Corporal Michael J. Crescenz VA Medical Center (642)

Subj: Comprehensive Healthcare Inspection of the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania

To: Director, VISN 4: VA Healthcare (10N4)

1. I have reviewed the VA OIG's draft report of the CHIP review conducted at the Corporal Michael J. Crescenz VA Medical Center. I concur with the OIG's recommendations.

   (Original signed by:)

   Karen Flaherty-Oxler
   Medical Center Director

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