US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Comprehensive Healthcare Inspection of the Erie VA Medical Center in Pennsylvania

CHIP Report | 22-00234-200 | September 13, 2023

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***Figure 1.*** *Erie VA Medical Center in Pennsylvania.*
*Source: https://www.va.gov/erie-health-care/locations/.*

# Abbreviations

| | |
|---|---|
| CHIP | Comprehensive Healthcare Inspection Program |
| CSRE | Comprehensive Suicide Risk Evaluation |
| 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 Erie VA Medical Center and associated outpatient clinics in Ohio and Pennsylvania. 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 Erie 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 five recommendations to the Chief of Staff in the Medical Staff Privileging and Mental Health areas of review. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 23.

## Conclusion

The OIG issued five recommendations for improvement to the Chief of Staff. 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 25-26, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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# Contents

# Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Erie 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 FY 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

# Methodology

The Erie VA Medical Center also provides care through associated outpatient clinics in Ohio and Pennsylvania. General information about the medical center can be found in appendix B.

The inspection team examined operations from March 16, 2018, 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 Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[5] The OIG's last comprehensive healthcare inspection of the Erie VA Medical Center occurred in March 2018. The Joint Commission performed hospital, behavioral health, and home care accreditation reviews in February 2020 and a laboratory accreditation review in October 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 Medical Center Director (Director), Chief of Staff, Associate Director of Patient Care Services, and Associate Medical Center Director (Associate Director). The Chief of Staff and Associate Director of Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for approximately one month, although the Director had served in the role since 2016, and the Associate Director of Patient Care Services since 2011. To help assess the executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Associate Director of Patient Care Services, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

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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 $221,583,106 had increased by approximately 19 percent compared to the previous year's budget of $185,820,948.[10] The Director reported using the largest portion of these funds to increase salaries and hire more staff.

## Employee Satisfaction

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

To assess employee attitudes toward the workplace, the OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[12]

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

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

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

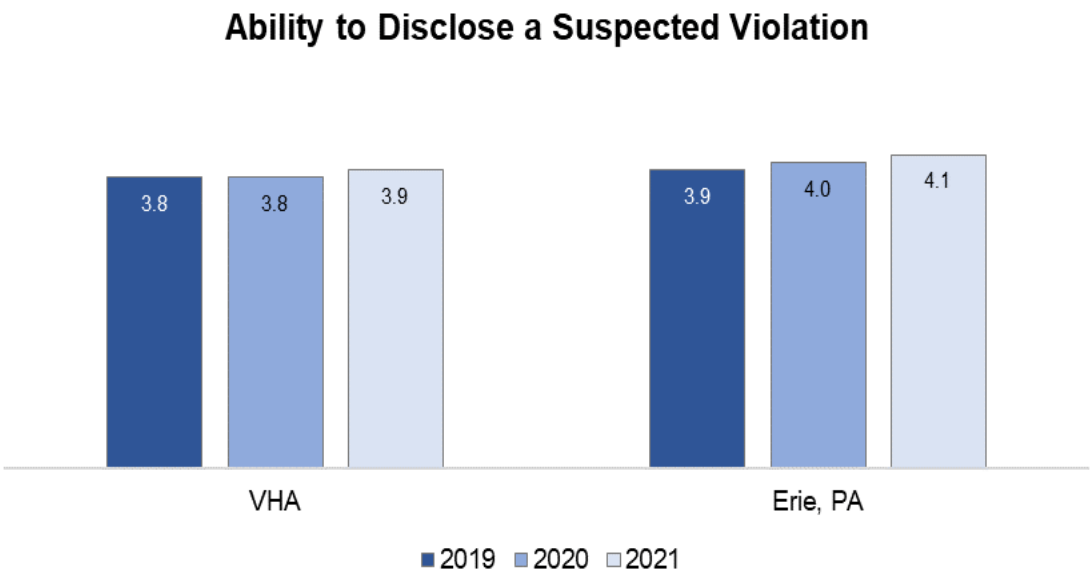


***Figure 2.*** *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

*Source: VA All Employee Survey (accessed May 10, 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.[13]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the medical center over time.[15]

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

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

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

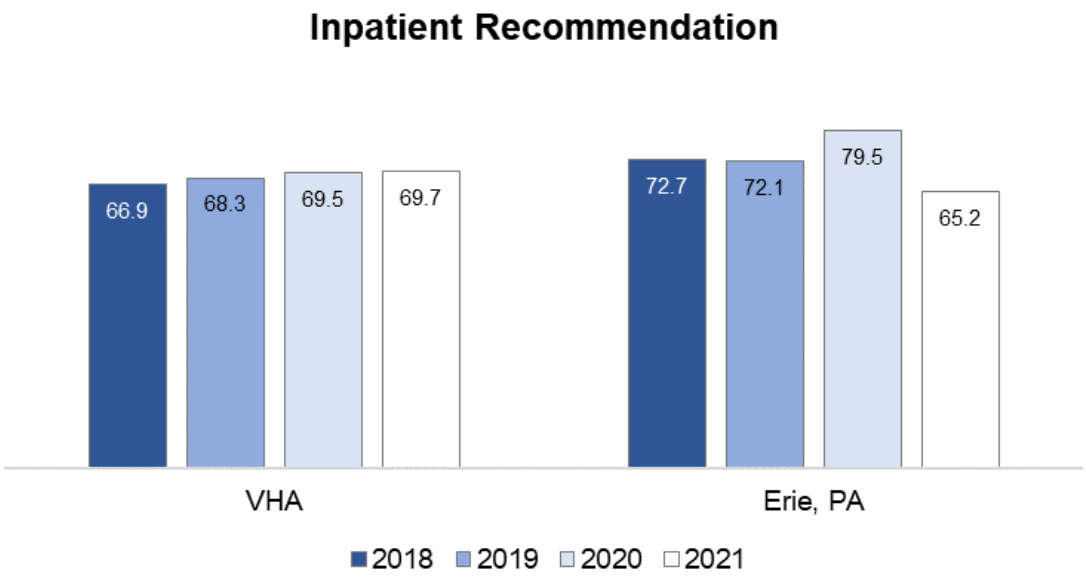


***Figure 3.*** *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

*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.*

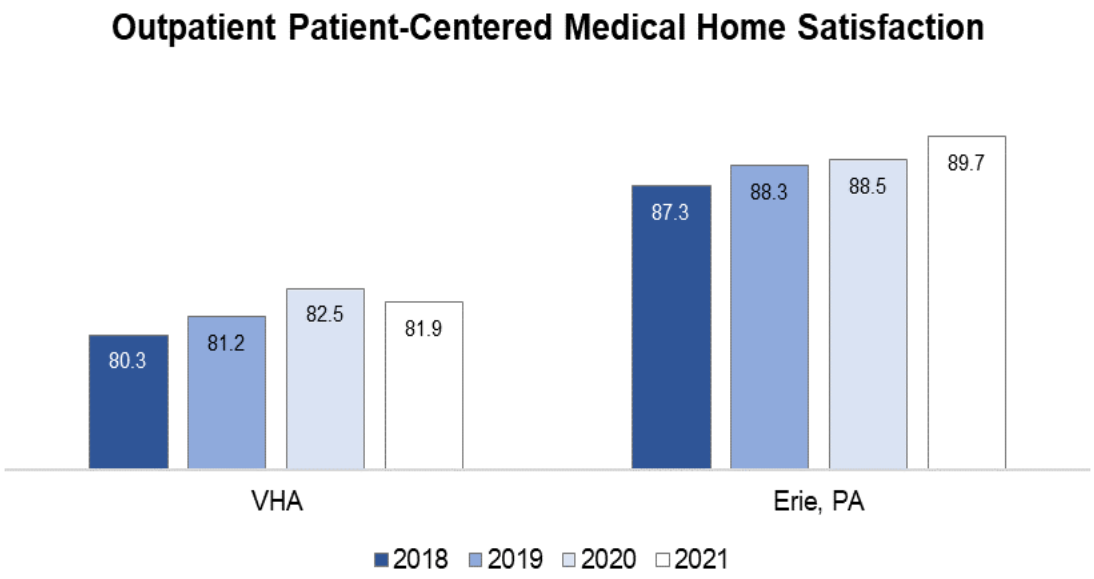


***Figure 4.*** *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

*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.*

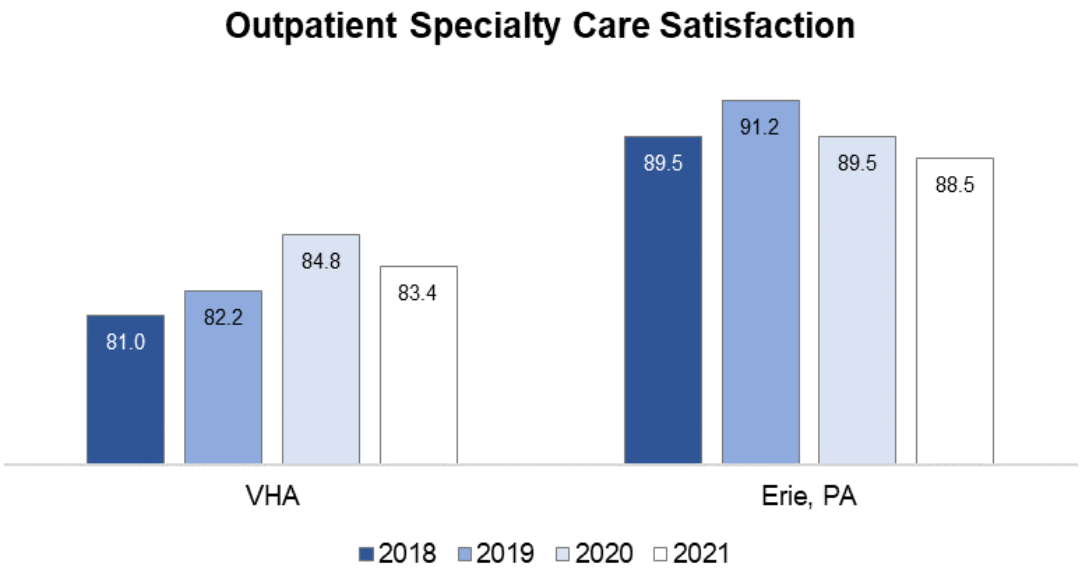


***Figure 5.*** *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

*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.[16] "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)."[17] 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

[16] 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/.

[17] 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."[18] 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."[19] 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.[20] 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.[21]

The OIG requested sentinel events and institutional and large-scale disclosures that occurred from March 16, 2018, through June 6, 2022, and reviewed the information staff reported. The Director reported being aware of patient safety issues and was generally knowledgeable regarding processes for institutional disclosures and actions taken by staff in response to sentinel events. The Director also described a standing meeting with quality management staff and key service chiefs to discuss safety events as well as close calls.

## Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[19] VHA Directive 1004.08.

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

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

## 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."[22] 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.[23] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[24]

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.[25] 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."[26] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[27]

Finally, the OIG assessed the medical center's culture of safety.[28] 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.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

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

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

[24] VHA Directive 1100.16.

[25] 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.

[26] VHA Directive 1190.

[27] VHA Directive 1190.

[28] 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.

## Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

## 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."[29] 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."[30]

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

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.[33]

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.[34] 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

[29] 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.)

[30] VHA Handbook 1100.19.

[31] VHA Handbook 1100.19.

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[35]

The OIG interviewed key managers and reviewed the privileging folders of 29 medical staff members who had an FPPE or OPPE.

## Medical Staff Privileging Findings and Recommendations

VHA required practitioners with similar training and privileges to complete professional practice evaluations.[36] Service chiefs consider those evaluations in recommending privileges.[37] The OIG found that FPPEs and OPPEs did not consistently have documented evidence a provider with similar training and privileges completed the evaluations. This could result in LIPs providing care without a thorough evaluation of their competency, which could adversely affect quality of care and jeopardize patient safety. The Chief of Staff stated that the medical director of a service (a surgeon) completed the FPPEs of several LIPs (anesthesiologists) and reported believing this met the standard. The Chief of Staff also stated that, due to further VISN guidance, the facility's FPPEs are now being sent to another VISN facility for review by a provider who has similar training and privileges.

## Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers with equivalent specialized training and similar privileges complete professional practice evaluations of licensed independent practitioners.

[35] 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.

[36] Acting Deputy Under Secretary for Health for Operations and Management memo, VHA Memorandum, Requirements for Peer Review of Solo Practitioners, August 29, 2016. (This memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on December 18, 2020. The December 18, 2020, memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on May 18, 2021.) VHA now requires another practitioner with equivalent specialized training and similar privileges to complete the professional practice evaluation. VHA Directive 1100.21(1).

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

Medical center concurred.

Target date for completion: December 31, 2023

Medical center response: In consultation with Office of Performance and Quality staff, the Chief of Staff reviewed the recommendation and identified ways to improve the credentialing and privileging process. The facility utilizes VISN assistance with Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) chart reviewers for solo/few practitioners with similar training and privileges while completing the FPPE/OPPE evaluation(s). The VISN process has been modified to ensure that reviewer's and reviewee's privileges are evaluated and compared for compliance. The Credentialing and Privileging Program Analyst will review solo/few providers to ensure that the proper evaluation of training and privileges was determined to be similar. Any reviewers not having similar training and education will be returned to the VISN to obtain the correct evaluation. For all other FPPEs and OPPEs, the Credentialing and Privileging Program Analyst will review the evaluations to ensure the reviewer has similar training and education to complete the evaluations.

The numerator will be the number of FPPE or OPPE forms showing evidence that results were contingent on an evaluation conducted by a similarly trained and privileged provider. The denominator will be the total number of FPPE or OPPE forms reviewed. The Credentialing and Privileging Program Manager will present the compliance results to the Medical Executive Council which the Chief of Staff chairs. Compliance will be tracked through the Medical Executive Council until the goal of 90 percent compliance is achieved and sustained for 6 consecutive months.

VHA requires that service chief incorporate service-specific criteria in OPPEs.[38] The OIG noted insufficient evidence of service-specific criteria for some OPPEs. This resulted in LIPs continuing to provide care without a thorough evaluation of their competency, which could potentially adversely affect quality of care and patient safety. The Credentialing and Privileging Manager stated that some of the chart review forms used in the past were non-service-specific and reported believing those forms met the requirement.

## Recommendation 2

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

[38] 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 within that specialty.

Medical center concurred.

Target date for completion: December 31, 2023

Medical center response: In consultation with the Office of Performance and Quality staff, the Chief of Staff reviewed the recommendation and identified ways to improve the credentialing and privileging process. Beginning in 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 conducts monthly monitoring of providers with service-specific criteria to consider for LIPs to ensure the facility meets the goal of 90 percent compliance for six consecutive months.

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 Council, which the Chief of Staff chairs. Compliance will be tracked through the Medical Executive Council until the goal of 90 percent compliance is achieved and sustained for 6 consecutive months.

VHA requires that service chiefs' recommendations to continue current privileges are based, in part, on OPPE activities such as direct observation, clinical discussions with other members of the care team, and review of diagnoses and treatments.[39] The OIG found that some practitioners' OPPEs lacked evidence service chiefs' recommendations to continue privileges were based, in part, on OPPE activities. When service chiefs' evaluations lack adequate data to support recommendations to continue privileges, it may negatively affect the delivery of quality patient care. The Credentialing and Privileging Manager stated that service chiefs did not document all evaluation activities.

## Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs' reprivileging recommendations are based, in part, on Ongoing Professional Practice Evaluation activities.

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

Medical center concurred.

Target date for completion: December 31, 2023

Medical center response: In consultation with the Office of Performance and Quality staff, the Chief of Staff reviewed the recommendation and identified ways to improve the credentialing and privileging process. The Erie 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 Erie VAMC updated all OPPE Summary Forms on 9/12/2022 to include measurements of competency, which also formatted an area in which the Service Chief recommends the options of continuing OPPE, initiating Focused Professional Practice Evaluation (FPPE), or initiating a plan for performance improvement as part of the overall evaluation of OPPE results. In May 2023, the Erie VAMC updated OPPE Evaluation Forms to include National and Facility Specialty-Specific chart reviews, supervisor observation, communication with clinical staff, and the data sources utilized to obtain the evaluation. The updated form also includes an area in which the Service Chief recommends privileges be continued, performance improvement areas, or other recommendations such as limited or revoked privileges 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; [and] limited or revoked privileges are based, in part, on OPPE activities. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. The numerator will be the number of Licensed Independent Providers (LIPs) with evidence of the Service Chief's determination of reprivileging based in part on OPPE activities. The denominator will the total number of LIPs reprivileged. Outcomes of the action items will be reported monthly to the Medical Executive Council (MEC) by the Credentialing and Privileging Program Manager, which the Chief of Staff chairs.

VHA requires the executive committee of the medical staff (known as the Medical Executive Committee at this medical center) to consider professional practice evaluation results in decisions to recommend privileges.[40] The OIG found inconsistent evidence the Medical Executive Committee's decisions to recommend LIPs' initial or continued privileges included consideration of FPPE or OPPE results; therefore, LIPs may have continued to deliver care without thorough evaluations of their practices. The Chief of Staff stated staff in clinical services kept documentation of professional practice evaluation activities instead of storing them in a

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

centralized location, which led to the Medical Executive Committee's inconsistent access to the documents.

## Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Medical Executive Committee considers professional practice evaluation results in decisions to recommend privileges.

Medical center concurred.

Target date for completion: December 31, 2023

Medical center response: In consultation with the Office of Performance and Quality staff, the Chief of Staff reviewed the recommendation and identified ways to improve the credentialing and privileging process. Through an electronic Practitioner Profile folder, clinical Service Chiefs and members of the Medical Executive Council review up to four previous Ongoing Professional Practice Evaluation (OPPE) cycles when recommending renewal of privileges. Clinical Service Chiefs attest in VetPro that OPPE results have been reviewed and no concerns are noted. The Service Chief's attestation in VetPro is added to the Medical Executive Council (MEC) agenda/minutes for the members to review. For new onboarded practitioners, the Medical Executive Council reviews the completed Focused Profession Practice Evaluation (FPPE) through an electronic Practitioner Profile folder when reviewing the Clinical Service Chief's recommendation for continuing of privileges. The Credentialing and Privileging Manager audits the MEC minutes to ensure the MEC minutes have the proper documentation of reprivileging and new onboarding practitioners.

The Credentialing and Privileging Manager will monitor until 90 percent compliance is achieved and sustained for six consecutive months. The numerator will be the number of Licensed Independent Practitioner's (LIP's) privileging decisions that reflect evidence of discussion of the FPPE/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 Council, which the Chief of Staff chairs.

## 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.[41] 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.[42]

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.[43] 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.[44]

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

- 5 Medicine unit

[41] 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.)

[42] 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.

[43] 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.

[44] 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.

- Dental clinic
- Community Living Center Alpha
- Community Living Center Beta (5 Nursing Home Care Unit)
- Oncology
- Outpatient primary care (White Clinic)
- Outpatient surgical specialty clinic
- Urgent care center

## Environment of Care Findings and Recommendations

The OIG made no recommendations.

## 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."[45] 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."[46]

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 (CSRE) when the screen is positive.[47] The OIG examined whether staff completed the CSRE 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."[48] 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 reviewed the electronic health records of 28 patients who were seen in the emergency department or urgent care center from December 31, 2020, through August 1, 2021.

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

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

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

[48] 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

VHA requires facility staff to "complete 100% of required universal and setting-specific screenings and CSREs."[49] The OIG determined that 29 percent of electronic health records reviewed lacked evidence staff completed the CSRE to assess the patient for suicide risk. Failure to complete a CSRE for patients with a positive suicide risk screen could result in missed opportunities for staff to intervene. The Chief, Behavioral Health reported that prior to receiving specific guidance from VHA's Office of Mental Health and Suicide Prevention in June 2021, the medical center's policy was for staff to not complete the CSRE for patients being transferred to the VA Pittsburgh Healthcare System.

## Recommendation 5

5. The Chief of Staff evaluates and determines additional reasons for noncompliance and ensures staff complete Comprehensive Suicide Risk Evaluations.

Medical center concurred.

Target date for completion: December 31, 2023

Medical center response: In consultation with the Office of Performance and Quality staff, the Chief of Staff reviewed the recommendation and identified ways to reduce the instances of patients leaving the Urgent Care Center setting without a Comprehensive Suicide Risk Evaluation. The facility has implemented a standardized protocol that all Veterans will be screened in Urgent Care Center triage using the Columbia-Suicide Severity Rating Scale (C-SSRS). If the C-SSRS is positive, a Comprehensive Suicide Risk Evaluation (CSRE) will be completed by a behavioral health licensed independent practitioner (LIP) during business hours or by the Urgent Care Center LIP or hospitalist after hours.

The Chief of Behavioral Health will conduct monthly monitoring of all positive C-SSRS in the Urgent Care Center triage area to ensure that a CSRE was completed the same day before the Veteran is transferred or discharged. The audits will continue until the facility meets the goal of 90 percent compliance for six consecutive months. The numerator will be the number of Comprehensive Suicide Risk Evaluation[s] (CSREs) completed the same day at the same location of the positive C-SSRS[s]. The denominator will be the number of positive C-SSRS[s]. The Chief of Behavioral Health will report compliance results to Office of Performance and Quality [OPQ] every month. The Chief of OPQ will report the outcomes of the monitoring activities to the Chief of Staff during the monthly Executive Leadership Board Committee meetings.

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

## 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 provided five 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 five OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Chief of Staff. The intent is for this leader to use the 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 | • None |
| Medical Staff Privileging | • Providers with equivalent specialized training and similar privileges complete professional practice evaluations of licensed independent practitioners.<br>• Service chiefs incorporate service-specific criteria in Ongoing Professional Practice Evaluations of licensed independent practitioners.<br>• Service chiefs' reprivileging recommendations are based, in part, on Ongoing Professional Practice Evaluation activities.<br>• The Medical Executive Committee considers professional practice evaluation results in decisions to recommend privileges. |
| Environment of Care | • None |
| Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives | • Staff complete Comprehensive Suicide Risk Evaluations. |

# Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) medical center reporting to VISN 4.[1]

**Table B.1. Profile for Erie VA Medical Center (562)**
**(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 | $141,683,821 | $185,820,948 | $221,583,106 |
| Number of: | | | |
| • Unique patients | 21,902 | 21,215 | 21,890 |
| • Outpatient visits | 268,012 | 247,545 | 270,074 |
| • Unique employees§ | 629 | 657 | 679 |
| Type and number of operating beds: | | | |
| • Community living center | 45 | 45 | 45 |
| • Domiciliary | 8 | 8 | 8 |
| • Medicine (Hospital) | 13 | 13 | 13 |
| Average daily census: | | | |
| • Community living center | 41 | 36 | 30 |
| • Domiciliary | 2 | 5 | 4 |
| • Medicine (Hospital) | 2 | 1 | 1 |

*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).*

[1] VHA medical facilities are classified according to a complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." "VHA Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES).

# Appendix C: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: August 7, 2023

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

Subj: Comprehensive Healthcare Inspection of the Erie VA Medical Center in Pennsylvania

To: Director, Office of Healthcare Inspections (54CH01)

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 Erie VA Medical Center in Pennsylvania.
2. I have reviewed the recommendations in the OIG draft report. I concur with the recommendations and action plans submitted by the Erie 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: August 3, 2023

From: Medical Center Director, Erie VA Medical Center in Pennsylvania (562)

Subj: Comprehensive Healthcare Inspection of the Erie VA Medical Center in Pennsylvania

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

1. I have reviewed the draft report of the Office of Inspector General (OIG) Comprehensive Inspection Program Review that was conducted at the Erie VA Medical Center. I concur with the OIG's recommendations outlined in this draft report.
2. I am submitting corrective action plans for each recommendation.
3. I appreciate the insights and guidance provided by OIG as a collaborative partner in assisting our facility to improve our processes as we strive to deliver high quality care for our Veterans.

*(Original signed by:)*

John A. Gennaro, FACHE, MHSA, MBA
Medical Center Director

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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