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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Wilkes-Barre VA Medical Center in Pennsylvania

CHIP Report | 22-00236-212 | September 19, 2023

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Figure 1. *Wilkes-Barre VA Medical Center in Pennsylvania.*
Source: https://www.va.gov/wilkes-barre-health-care/ (accessed October 13, 2022).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Wilkes-Barre VA Medical Center and multiple outpatient clinics in 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 virtual inspection of the Wilkes-Barre VA Medical Center during the week of July 11, 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 four recommendations to the Director, Chief of Staff, and Associate Director in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 21.

Conclusion

The OIG issued four recommendations for improvement to the Director, Chief of Staff, and Associate Director. 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 23–24, 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.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

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 Wilkes-Barre 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 Wilkes-Barre VA Medical Center includes associated outpatient clinics in Pennsylvania. General information about the medical center can be found in appendix B.

The inspection team examined operations from July 29, 2017, through July 14, 2022, the last day of the unannounced multiday evaluation.[5] During the virtual 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 medical center 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 Wilkes-Barre VA Medical Center occurred in July 2017. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews that commenced in September 2020 and a laboratory accreditation survey in March 2022.

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

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their 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, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. The Chief of Staff and Associate Director for Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the medical center's leadership team appeared stable; executive leaders had worked together for over five and a half years since the appointment of the Director in October 2016. The Chief of Staff, assigned in May 2008, was the most tenured member. The Associate Director for Patient Care Services and Associate Director were appointed in November 2012 and August 2013, respectively. To help assess the executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Associate Director for

[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.

Patient Care Services, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2021 annual medical care budget of $386,456,630 had increased by approximately 11 percent compared to the previous year's budget of $347,872,334.[10] The Director stated the budget increase allowed executive leaders to address specialty care needs, hire more staff to provide additional services, and reduce the number of patients referred to providers outside of the medical center. The Associate Director explained that leaders also used the extra funds to build trailer-like structures outside the medical center for COVID-19 screening and testing and purchase new equipment.

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.

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.[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).

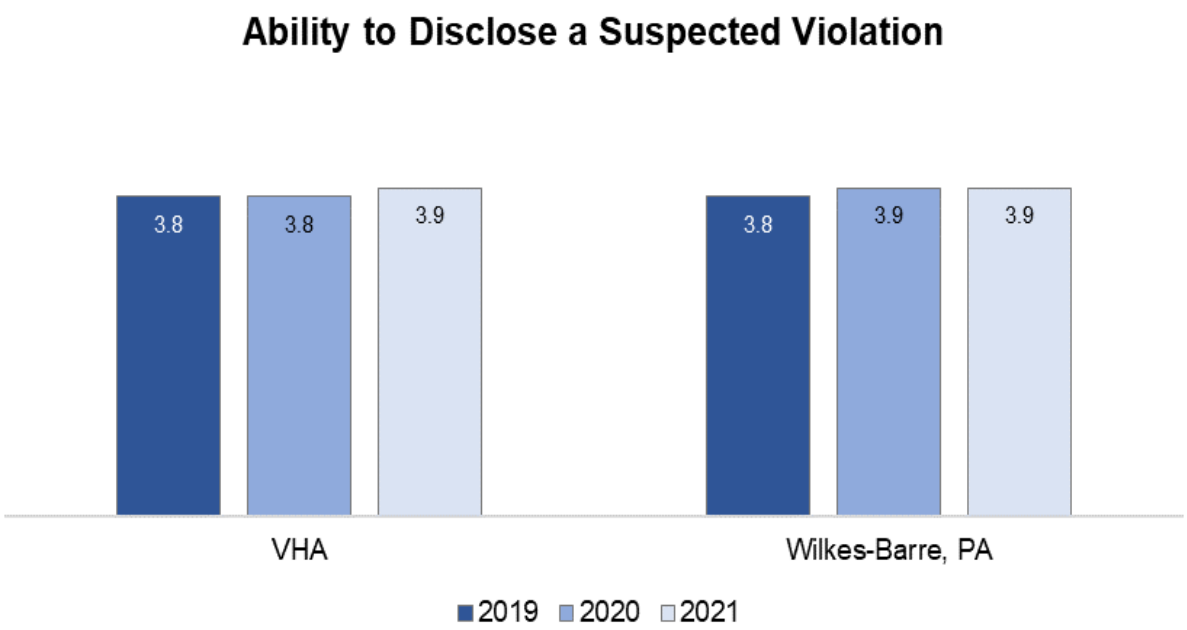

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed June 8, 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 assess patients' healthcare experiences and compare them to 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.

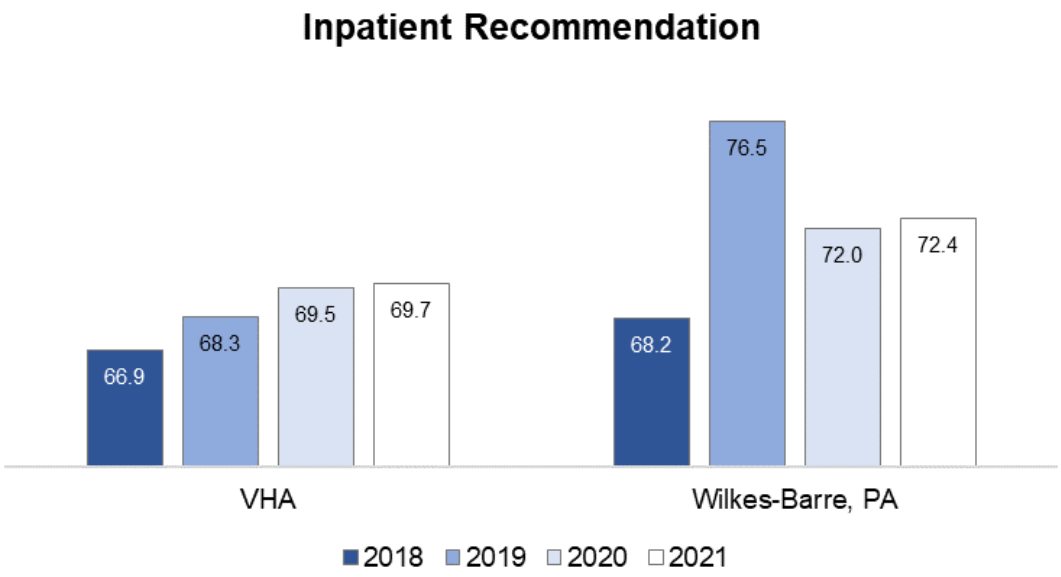

Figure 3. *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

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.

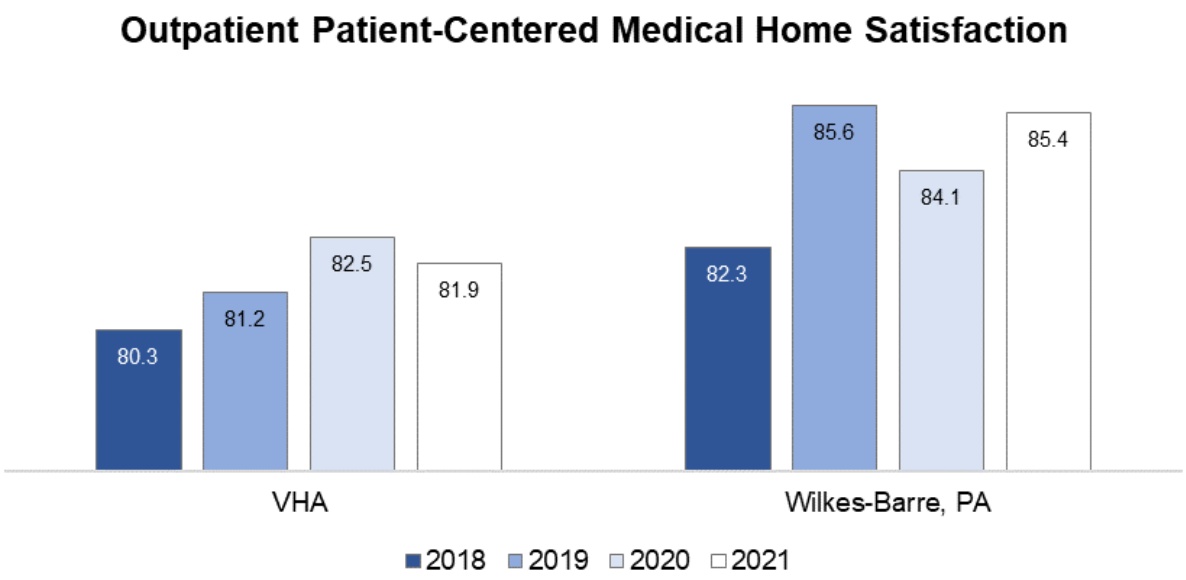

Figure 4. *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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.

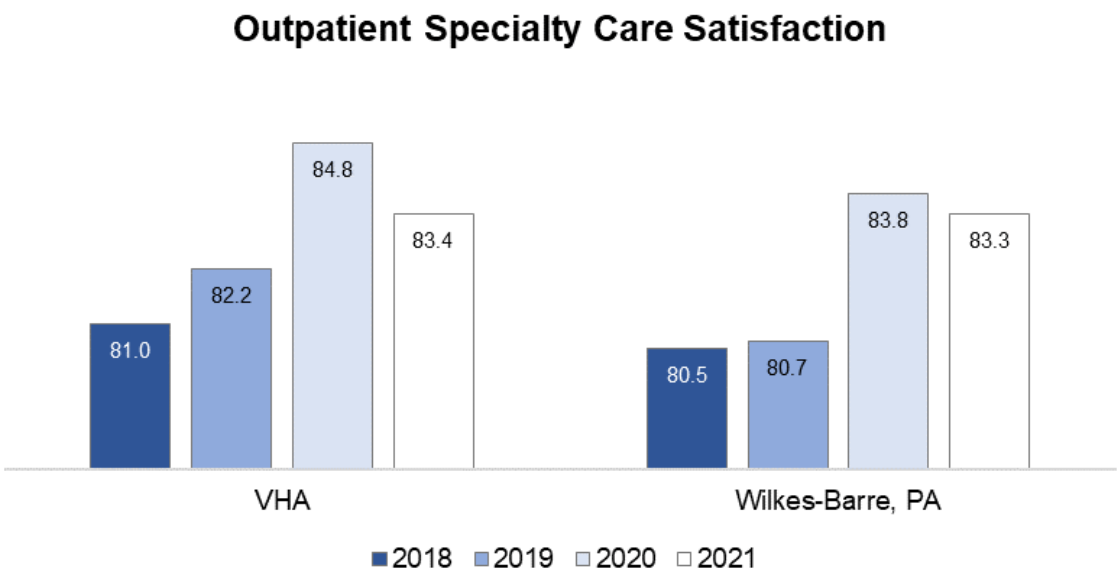

Figure 5. *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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 adverse events that occurred from July 29, 2017, through July 10, 2022, and reviewed the information staff reported. The Director described staff reporting serious patient safety event information daily and the Patient Safety Manager bringing all events forward for discussion. The Director also spoke about incorporating incidents from the patient safety event reporting system in morning reports as part of the medical center's high reliability organization safety huddles.[22] For institutional disclosures, the Director reported depending on the Chief of Staff and Risk Manager to determine when disclosures were warranted and implementing a more robust patient safety event reporting process which included comprehensive follow-up to address all delinquent action items. The Director further mentioned receiving written notification of any action items exceeding the due date.

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.

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

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."[23] 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.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[25]

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.[26] 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."[27] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[28]

Finally, the OIG assessed the medical center's culture of safety.[29] 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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[23] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[24] 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.)

[25] VHA Directive 1100.16.

[26] 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.

[27] VHA Directive 1190.

[28] VHA Directive 1190.

[29] 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."[30] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[31]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[32] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[33]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when 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.[34]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[35] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the chief of staff. VHA also requires facilities to have credentialing

[30] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[31] VHA Handbook 1100.19.

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Directive 1100.20.

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

The OIG interviewed key managers and reviewed the privileging folders of 28 medical staff members who had a Focused Professional Practice Evaluation or OPPE.

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to incorporate service-specific criteria in OPPEs.[37] The OIG found that OPPEs did not consistently contain evidence of service-specific criteria. This may have resulted in service chiefs' evaluations lacking adequate data to support recommendations to continue privileges. The Credentialing and Privileging Manager reported using OPPE forms in the past that did not specify service-specific criteria and believed these forms met the requirement.

Recommendation 1

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

Medical center concurred.

Target date for completion: April 1, 2024

Medical center response: In consultation with the Quality Management Services staff, the Chief of Staff reviewed the recommendations and identified ways to improve the credentialing and privileging process. As of March 1, 2022, the Credentialing and Privileging staff has incorporated the required clinical indicators which includes service/specialty-specific criteria into the Ongoing Professional Practice Evaluation (OPPE) forms. The Credentialing and Privileging Manager will monitor and track all completed OPPE forms monthly. The numerator is the number of completed OPPE forms that include service/specialty-specific criteria. The denominator is the number of reviewed OPPEs each month. The Credentialing and Privileging Manager will report the monthly compliance rate to the Medical Executive Council, chaired by the Chief of Staff, until 90 percent or higher compliance is achieved and maintained for six consecutive months.

[36] 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.

[37] 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.

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.[38] 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.[39]

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.[40] 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.[41]

Environment of Care Findings and Recommendations

VHA requires staff to complete comprehensive environment of care inspections at "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in patient care areas."[42] The OIG found that staff did not complete the required inspections of the intensive care unit, operating room, recovery room, or in six of seven community-based outpatient clinics during FY 2021.[43] As a result, leaders may have been unable to identify all potential patient safety risks and deficiencies. The Safety and Occupational Health Manager and Associate Director stated

[38] 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.)

[39] The OIG conducted this review virtually.

[40] 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.

[41] 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.

[42] VHA Directive 1608.

[43] These community-based outpatient clinics are the Columbia County VA Clinic, Northampton County VA Clinic, Sayre VA Clinic, Tobyhanna VA Clinic, Wayne County VA Clinic, and Williamsport VA Clinic.

that staff postponed inspections due to COVID-19 pandemic restrictions. The Safety and Occupational Health Manager also reported misunderstanding the medical center's restrictions and being unaware of the requirement to continue environment of care inspections.

Recommendation 2

2. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures staff conduct comprehensive environment of care inspections at the required frequency.

Medical center concurred.

Target date for completion: April 1, 2024

Medical center response: The Associate Director reviewed the recommendations and did not identify any additional reason for noncompliance. The Safety and [Occupational] Health Manager developed an inspection schedule to address the incomplete inspections and ensure compliance. Beginning August 1, 2022, a schedule was implemented to ensure all patient care areas have completed inspections for a minimum of twice per fiscal year as per VHA Directive 1608. The Safety & Health Manager will monitor and track all completed inspections monthly. The numerator is the number of completed inspections each month. The denominator is the number of inspections scheduled for that month. The Safety & Health Manager will report the monthly compliance rate to the Administrative Executive Council until 90 percent or higher compliance is achieved and maintained for six consecutive months.

VHA requires staff to periodically test panic alarms in the inpatient mental health unit and document VA police response times.[44] The OIG did not receive evidence staff documented police response times for panic alarm testing in the inpatient mental health unit. This may result in an unsafe environment for patients, visitors, and staff since timely response greatly affects the overall success of police intervention and reduction of organizational risks. The Chief of Police reported being unaware of the requirement.

Recommendation 3

3. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures staff document VA police response times for panic alarm testing in the inpatient mental health unit.

[44] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," March 7, 2022; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," April 10, 2023.

Medical center concurred.

Target date for completion: April 1, 2024

Medical center response: The Associate Director reviewed the recommendations and did not identify any additional reason for noncompliance. As of September 1, 2022, the Physical Security Specialist began conducting panic alarm testing and documentation of police response times in the locked inpatient mental health unit. The Physical Security Specialist monitors and tracks all completed inspections monthly and will report to the Administrative Executive Council for two quarters. The numerator will be the number of completed panic alarm testing and documented police response times. The denominator will be the number of scheduled panic alarm testing. Testing and documentation of police response times will be monitored until 90 percent or higher compliance is achieved and maintained for six consecutive months.

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 when the screen is positive.[47] 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."[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 47 randomly selected 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 providers to complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.[49] VHA also states that providers should complete the Comprehensive Suicide Risk Evaluation on the same day as the positive suicide risk screen for outpatients and within 24 hours for patients in all other settings.[50] The OIG found that providers did not complete the Comprehensive Suicide Risk Evaluation for 26 percent of patients. Of the evaluations completed, the OIG found that providers did not complete them within the required time frame for 40 percent of patients. Failure to evaluate patients with a positive suicide risk screen, or evaluate them in a timely manner, could result in missed opportunities for staff to intervene. The Suicide Prevention Coordinator stated providers were unaware of the requirement due to lack of training.

Recommendation 4

4. The Director evaluates and determines any additional reasons for noncompliance and ensures providers complete the Comprehensive Suicide Risk Evaluation within the required time frame for patients with a positive suicide risk screen.

[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)."

[50] 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."

Medical center concurred.

Target date for completion: April 1, 2024

Medical center response: The Director reviewed the recommendations and did not identify any additional reason for noncompliance. Beginning September 1, 2022, training and education was implemented for all mental health service staff and emergency department licensed independent practitioners on appropriate completion of Comprehensive Suicide Risk Evaluation (CSRE). Weekly trainings and learning opportunities on the Columbia Suicide Severity Rating Scale (C-SSRS) and CSRE are offered via Suicide Prevention Lunch and Learn. Daily monitoring of missed opportunities continues to be conducted by suicide prevention staff. For positive C-SSRS screen without timely completion of CSRE, suicide prevention staff will report and follow up with supervisors and providers. The Suicide Prevention Coordinator and Mental Health Service Associate Chief of Staff (ACOS) will monitor the completion rate for positive C-SSRS in the Emergency Department (ED) for progress by reviewing the Safety Planning in ED/UCC [urgent care center] Suicide Prevention Detail Report monthly. The numerator will be the number of CSRE screens completed within 24 hours of a positive C-SSRS. The denominator will be the number of C-SSRS positive screens. The Mental Health Service ACOS or representative will report CSRE completion rates for positive C-SSRS in the ED monthly to the Clinical Executive Council, chaired by the Chief of Staff. Timely completion of CSRE will be monitored until 90 percent or higher compliance is achieved and maintained for six consecutive months.

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 four 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 four 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. 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	• None
Medical Staff Privileging	• Service chiefs incorporate service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.
Environment of Care	• Staff conduct comprehensive environment of care inspections at the required frequency. • Staff document VA Police response times for panic alarm testing in the inpatient mental health unit.
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation within the required time frame for patients with a positive suicide risk screen.

Appendix B: Medical Center Profile

The table below provides general background information for this medium complexity (2) affiliated medical center reporting to VISN 4.[1]

Table B.1. Profile for Wilkes-Barre VA Medical Center (693) (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	$270,582,804	$347,872,334	$386,456,630
Number of:			
• Unique patients	37,656	35,294	37,786
• Outpatient visits	405,252	370,037	427,005
• Unique employees§	1,170	1,178	1,233
Type and number of operating beds:			
• Community living center	105	105	105
• Domiciliary	10	10	10
• Medicine (Hospital)	58	58	58
Average daily census:			
• Community living center	103	71	59
• Domiciliary	9	4	4
• Medicine (Hospital)	26	24	24

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 centers are classified according to a complexity model; a designation of "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." "VHA 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.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 30, 2023

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

Subj: Comprehensive Healthcare Inspection of the Wilkes-Barre 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 Wilkes-Barre 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 Wilkes Barre VA Medical Center.

(Original signed by:)

Timothy W. Liezert
Network Director, VISN 4

Appendix D: Director Comments

Department of Veterans Affairs Memorandum

Date: August 28, 2023

From: Director, Wilkes-Barre VA Medical Center (693)

Subj: Comprehensive Healthcare Inspection of the Wilkes-Barre VA Medical Center in Pennsylvania

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

1. Thank you for the opportunity to review the draft report, Comprehensive Healthcare Inspection of the Wilkes-Barre 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 Wilkes-Barre VA Medical Center in Pennsylvania.

(Original signed by:)

Russell E. Lloyd
Medical Center Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Robert Ordonez, MPA, Team Leader Cheryl Walsh, MS, RN, Team Leader Debra Baskin, DNP, RN Christine El-Zoghbi, PhD Megan Magee, MSN, RN Kara McDowell, BSN, RN Simonette Reyes, BSN, RN
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Elisa Gomez, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Karla Kisiel, BSN, RN Carol Manning, MSW, MPH Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Jarvis Yu, MS

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