US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 21: VA Sierra Pacific Network in Pleasant Hill, California

CHIP Report | 22-00065-08 | November 1, 2023

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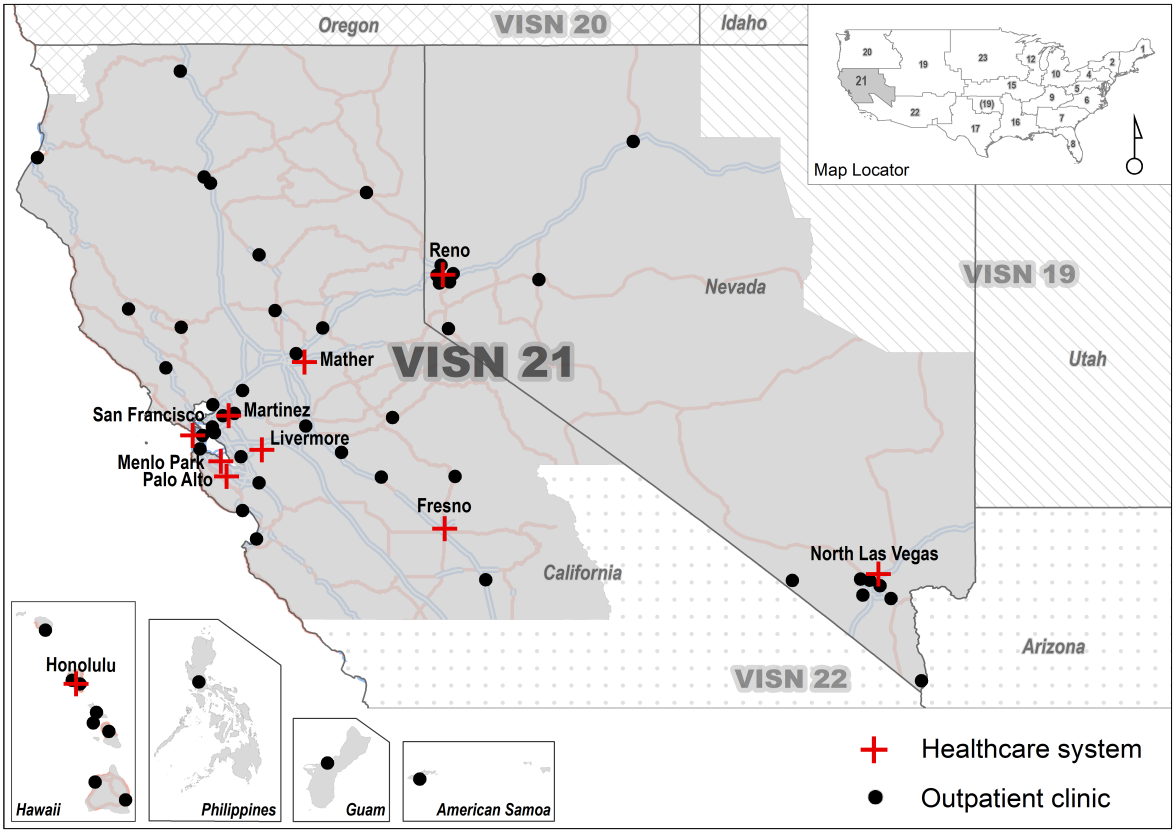

Figure 1. *Veterans Integrated Service Network 21: VA Sierra Pacific Network.*

Source: Veterans Health Administration Site Tracking System (accessed May 16, 2022).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CMO	Chief Medical Officer
FY	fiscal year
HCS	health care system or healthcare system
OIG	Office of Inspector General
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by Veterans Integrated Service Network (VISN) 21: VA Sierra Pacific Network in Pleasant Hill, California.[1] The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each VISN approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following areas of clinical and administrative operations:

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

The OIG conducted an unannounced on-site inspection of the VA Sierra Pacific Network beginning the week of May 16, 2022. The OIG also inspected the following VISN 21 facilities during the weeks of April 4, April 11, April 25, May 2, and May 9, 2022:

- Manila VA Clinic (Pasay City, Philippines)
- San Francisco VA Health Care System (California)
- VA Central California Health Care System (Fresno)
- VA Northern California Health Care System (Mather)
- VA Pacific Islands Health Care System (Honolulu, Hawaii)
- VA Palo Alto Health Care System (California)
- VA Sierra Nevada Health Care System (Reno)
- VA Southern Nevada Healthcare System (North Las Vegas)

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

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. The findings presented in this report are a snapshot of VISN 21 and facility performance within the identified focus areas at the time of the OIG inspection. The findings may help VISN leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Conclusion

The OIG did not issue recommendations for improvement related to the areas reviewed for this report. The number of recommendations should not be used as a gauge for the overall quality of care provided within this VISN.

VA Comments

The Veterans Integrated Service Network Director concurred with the report (see appendix B, page 18, for the full text of the Director's comments).

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

Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 21: VA Sierra Pacific Network.[1] This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so they can make informed decisions to improve care.

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

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

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

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

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. Sfantou et al., "Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] CHIP 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 inspection team examined operations from August 24, 2017, through May 25, 2022, the last day of the unannounced multiday inspection.[5] During the visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline. The OIG also inspected the following VISN 21 facilities beginning the weeks of April 4, April 11, April 25, May 2, and May 9, 2022:

- Manila VA Clinic (Pasay City, Philippines)[6]
- San Francisco VA Health Care System (HCS) (California)
- VA Central California HCS (Fresno)[7]
- VA Northern California HCS (Mather)[8]
- VA Pacific Islands HCS (Honolulu, Hawaii)[9]
- VA Palo Alto HCS (California)[10]
- VA Sierra Nevada HCS (Reno)[11]
- VA Southern Nevada HCS (North Las Vegas)[12]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[13] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[5] The range represents the time from the previous comprehensive healthcare inspection of the VA Northern California Health Care System (HCS) (Mather) to the completion of the CHIP visit.

[6] The VA Manila Outpatient Clinic is part of VISN 21 and provides outpatient care to veterans residing in or visiting the Republic of the Philippines. The care provided is limited to the scope of services and the capacity of the clinic.

[7] The VA Central California HCS's primary campus is the Fresno VA Medical Center (VAMC).

[8] The VA Northern California HCS includes the Martinez and Sacramento VAMCs.

[9] The VA Pacific Islands HCS's primary campus is the Spark M. Matsunaga VAMC.

[10] The VA Palo Alto HCS includes the Palo Alto VAMC, Palo Alto VAMC–Livermore, and Palo Alto VAMC–Menlo Park.

[11] The VA Sierra Nevada HCS's primary campus is the Ioannis A. Lougaris VAMC.

[12] The VA Southern Nevada HCS's primary campus is the North Las Vegas VAMC.

[13] 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.[14] 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."[15] 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.[16]

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

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

Executive Leadership Position Stability

The VISN is defined based on "VHA's [Veterans Health Administration's] natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs [VA medical centers], clinics and other sites; contractual arrangements with private providers; sharing agreements and other government providers. The VISN is designed to be the basic budgetary and planning unit of the Veterans healthcare system."[17]

The VA Sierra Pacific Network consists of seven VA HCSs and multiple community-based outpatient clinics in Nevada, northern and central California, Hawaii, Philippines, and US territories in the Pacific basin.

According to data from the VA National Center for Veterans Analysis and Statistics, VISN 21 had a veteran population of 1,061,578 at the beginning of fiscal year (FY) 2022 and a projected

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

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

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

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

population of 1,034,487 for FY 2023. The VISN provided care for 380,565 unique patients in FY 2019, 372,582 in FY 2020, and 406,159 in FY 2021. As of May 16, 2022, the VISN employed 22,786 staff. This total included an FY 2021 net gain of 266 and an FY 2022 net gain of 486 employees.

The VISN medical care budget for FY 2019 was $4,243,616,035; for FY 2020, $5,206,685,304; and for FY 2021, $5,788,206,557. This represents a two-year increase of over 36 percent.

At the time of the OIG's visit, VISN 21 had an executive leadership team consisting of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), and Quality Management Officer/Chief Nursing Officer. The executive leaders had worked together for nearly two years. The CMO was assigned to the position in August 2020. The Network Director and Deputy Network Director were assigned in 2018, and the Quality Management Officer/Chief Nursing Officer in 2019.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[18] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on VISN leaders.

The OIG reviewed VA's All Employee Survey satisfaction results from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal (see figure 2).[19]

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

[19] 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).

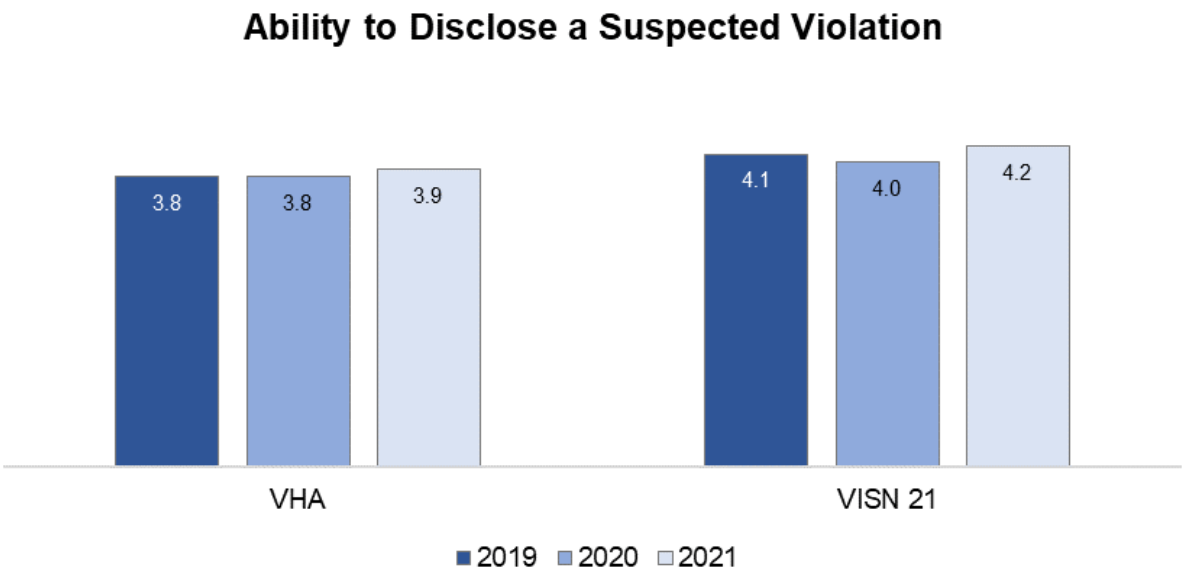

Figure 2. *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

Source: VA All Employee Survey (accessed April 13, 2022).

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

Patient Experience

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.[20]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[21] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the VISN from FYs 2018 through 2021. Figures 3–5 provide relevant survey results for VHA and VISN 21.[22]

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

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

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

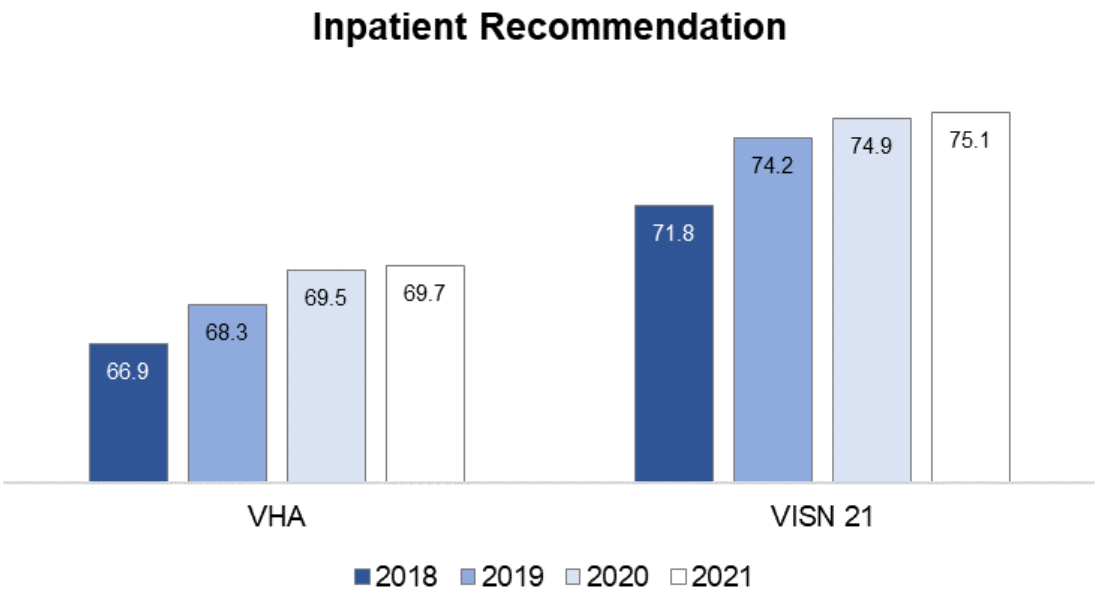

Figure 3. *Survey of Healthcare Experiences of Patients (Inpatient): Would you recommend this hospital to your friends and family?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed April 12, 2022).

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

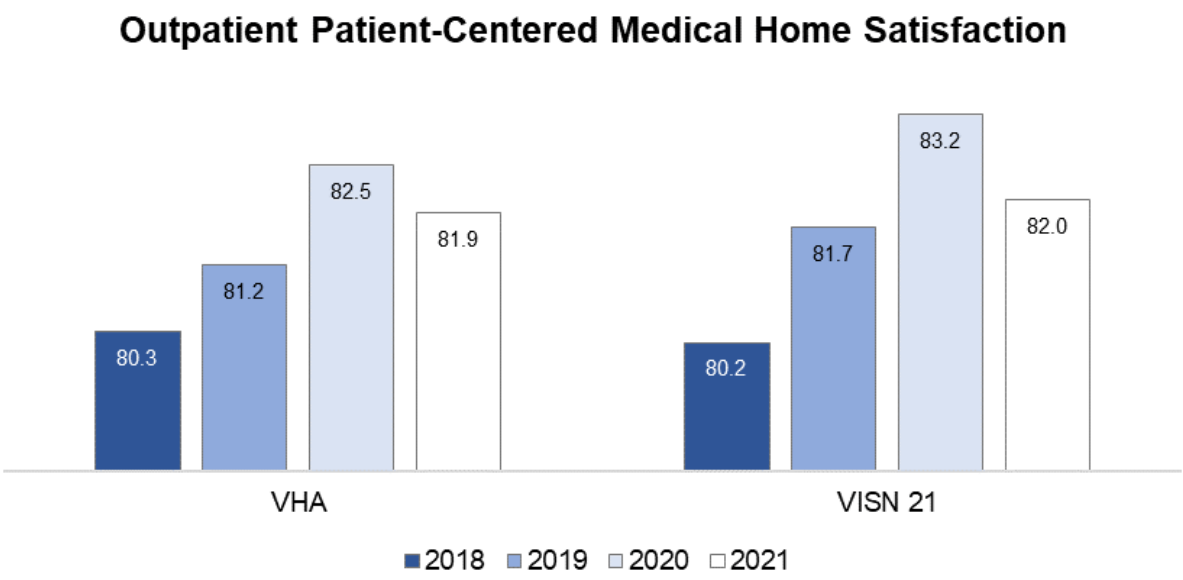

Figure 4. *Survey of Healthcare Experiences of Patients (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed April 12, 2022).

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

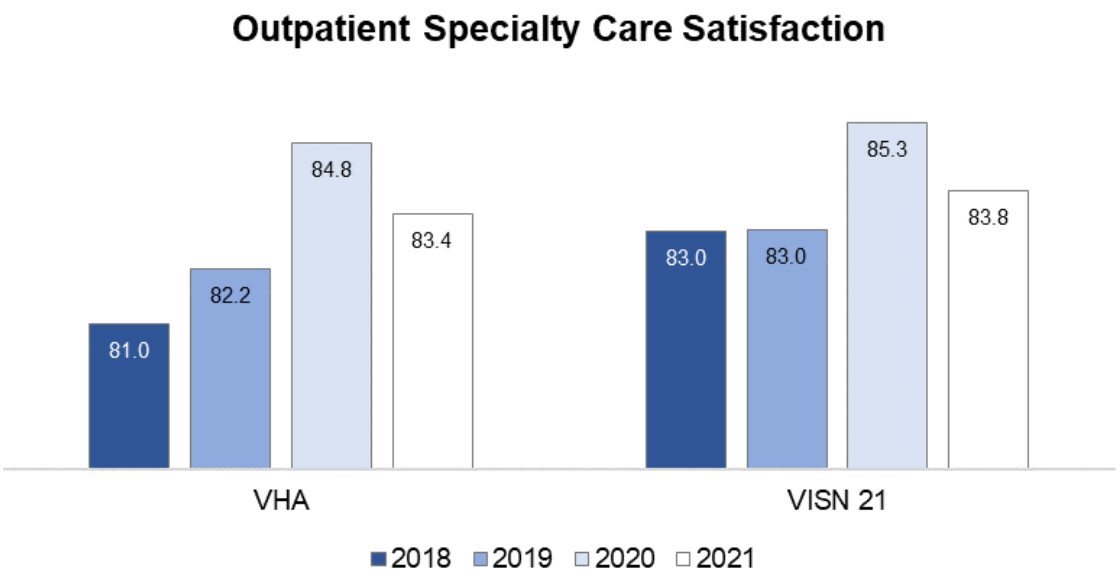

Figure 5. *Survey of Healthcare Experiences of Patients (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed April 12, 2022).

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

Access to Care

A VA priority is ensuring timely access to the best care and benefits for the nation's veterans. VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates. VHA's goal is to provide patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[23]

To examine access to primary and mental health care in VISN 21, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics

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

for the most recently completed quarter. Tables 1 and 2 provide wait time statistics for completed primary care and mental health appointments from January 1 through March 31, 2022.[24]

Table 1. Primary Care Appointment Wait Times (January 1 through March 31, 2022)

Facility	Average New Patient Wait Times from Create Date (Days)
VISN 21	20.8
Manila VA Clinic (Pasay City)	59.1
San Francisco VA HCS (CA)	16.4
VA Central California HCS (Fresno)	12.1
VA Northern California HCS (Mather)	16.5
VA Pacific Islands HCS (Honolulu, HI)	20.3
VA Palo Alto HCS (CA)	34.2
VA Sierra Nevada HCS (Reno)	22.5
VA Southern Nevada HCS (North Las Vegas)	27.3

Source: VA Corporate Data Warehouse (accessed April 13, 2022, and September 14, 2023).

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

[24] Primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine. For the Manilla VA Clinic, primary care wait times are for general/internal medicine. Mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual.

Table 2. Mental Health Appointment Wait Times (January 1 through March 31, 2022)

Facility	Average New Patient Wait Times from Create Date (Days)
VISN 21	15.8
Manila VA Clinic (Pasay City)	40.6
San Francisco VA HCS (CA)	12.2
VA Central California HCS (Fresno)	18.0
VA Northern California HCS (Mather)	17.2
VA Pacific Islands HCS (Honolulu, HI)	9.1
VA Palo Alto HCS (CA)	16.3
VA Sierra Nevada HCS (Reno)	11.6
VA Southern Nevada HCS (North Las Vegas)	19.6

Source: VA Corporate Data Warehouse (accessed April 13, 2022).

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

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

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

The inspection team interviewed managers and reviewed meeting minutes and other relevant documents and determined VISN staff generally complied with OIG-identified key processes for quality and safety.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

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

[27] VHA Directive 1100.16.

Medical Staff Credentialing and Privileging

The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with the VHA policy," which includes the VISN CMO's oversight of credentialing and privileging processes at VISN facilities.[28] "Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system. Credentials are documented evidence of licensure, education, training, experience, or other qualifications."[29]

When certain actions are taken against a physician's license, the senior strategic business partner (previously known as the human resources officer) will make a recommendation to the VISN chief human resources officer, who will then determine whether the physician meets licensure requirements for VA employment.[30] Further, the VISN CMO is required to document a review for any licensed independent practitioner with a history of a licensure action or malpractice history.[31] The VISN CMO must then "make a recommendation to the VHA medical facility that initiated the review process on the appropriateness of continuing with the LIP's [licensed independent practitioner's] credentialing application or appointment at the facility."[32]

The OIG inspection team reviewed information for 263 VISN facility physicians hired after January 1, 2021.[33] When reports from the National Practitioner Data Bank or Federation of State Medical Boards appeared to confirm that a physician had a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

[28] 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.)

[29] VHA Directive 1100.20.

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

[31] VHA Credentialing Directive 1100.20: Standard Operating Procedure – 40 version 1, *Conducting and Documenting a Chief Medical Officer Credentials Review,* November 9, 2020. A licensed independent practitioner "is any individual permitted by law...and the facility to provide patient care services independently, i.e., without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." VHA Handbook 1100.19.

[32] VHA Credentialing Directive 1100.20: Standard Operating Procedure–40 version 1.

[33] The VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, [and] focused on the approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards." GAO, *Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6, February 2019.

- VISN Chief Human Resource Officer's review to determine whether the physician satisfies VA licensure requirements, and
- VISN CMO's review and recommendation for any licensed independent practitioner with a specific licensure or malpractice history.[34]

The OIG interviewed leaders and reviewed relevant documents and determined VISN staff generally complied with the requirements listed above.

Medical Staff Credentialing and Privileging Findings and Recommendations

The OIG made no recommendations.

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

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that staff at healthcare facilities provide a safe, clean, and functional environment of care for veterans, their families, visitors, and employees in accordance with applicable Joint Commission environment of care standards and federal regulatory, VA, and VHA requirements.[35] 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.

To support these efforts, VHA requires VISNs to have a Comprehensive Environment of Care "oversight program with a charter."[36] VHA also mandates that VISN leaders ensure staff at network facilities with acute inpatient mental health units submit their Mental Health Environment of Care Checklist review via the Patient Safety Assessment Tool every six months.[37]

The OIG inspection team reviewed relevant documents and interviewed managers and determined VISN staff generally complied with various environment of care requirements.

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[35] 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. VHA amended this directive September 7, 2023.) VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[36] VHA Directive 1608.

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

Mental Health: Suicide Prevention

Suicide prevention remains the top clinical priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides among U.S. adults."[38] 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."[39]

VHA requires VISN leaders to appoint mental health staff to serve on the primary VISN governing body, participate on each state's suicide prevention council or workgroup, coordinate activities with state and local mental health systems and community providers, and serve as the VISN representative for the Suicide Prevention Program.[40]

The OIG reviewed relevant documents and interviewed managers and determined VISN staff generally complied with various suicide prevention requirements.

Mental Health Findings and Recommendations

The OIG made no recommendations.

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

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

[40] VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.) VHA Directive 1160.07, *Suicide Prevention Program,* May 24, 2021.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care within this VISN, the OIG conducted a detailed review of five clinical and administrative areas and did not issue recommendations for improvement.

Appendix A: VISN 21 Profile

The table below provides general background information for VISN 21.

Table A.1. Profile for VISN 21
(October 1, 2018, through September 30, 2021)

Profile Element	VISN Data FY 2019*	VISN Data FY 2020†	VISN Data FY 2021‡
Total medical care budget	$4,243,616,035	$5,206,685,304	$5,788,206,557
Number of:			
• Unique patients	380,565	372,582	406,159
• Outpatient visits	4,850,800	4,560,560	5,308,552
Unique employees§	16,746	18,151	18,896
Type and number of operating beds:			
• Community living center	774	780	729
• Domiciliary	204	204	218
• Hospital	679	689	677
Average daily census:			
• Community living center	831	605	475
• Domiciliary	133	85	51
• Hospital	507	393	396

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

**October 1, 2018, through September 30, 2019.*
†October 1, 2019, through September 30, 2020.
‡October 1, 2020, through September 30, 2021.
§Unique employees involved in direct medical care (cost center 8200).

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 5, 2023

From: Director, VA Sierra Pacific Network (10N21)

Subj: Comprehensive Healthcare Inspection of Veterans Integrated Service Network 21: VA Sierra Pacific Network in Pleasant Hill, California

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

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

Thank you for conducting the Comprehensive Healthcare Inspection (OIG) of Veterans Integrated Service Network 21 review during the week of May 16, 2022.

I have reviewed the document and concur with the report. I am very proud of our VISN 21 team and this outstanding report, which reflects the excellent care we provide to our Veterans every day.

(Original signed by:)

Ada Clark, FACHE, MPH
Network Director
VA Sierra Pacific Network (VISN 21)

OIG Contact and Staff Acknowledgments

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Board of Veterans' Appeals
Director, VISN 21: VA Sierra Pacific Network

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House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
- California: Laphonza R. Butler, Alex Padilla
- Hawaii: Mazie K. Hirono, Brian Schatz
- Nevada: Catherine Cortez Masto, Jacky Rosen

US House of Representatives
- American Samoa: Amata Coleman Radewagen
- California: Ami Bera, Jim Costa, Mark DeSaulnier, Anna G. Eshoo, John Garamendi, Jimmy Gomez, Josh Harder, Jared Huffman, Ro Khanna, Doug LaMalfa, Barbara Lee, Zoe Lofgren, Doris Matsui, Kevin McCarthy, Tom McClintock, Kevin Mullin, Grace F. Napolitano, Jimmy Panetta, Nancy Pelosi, Eric Swalwell, Mike Thompson, David G. Valadao
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