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

Office of Healthcare Inspections

**VETERANS HEALTH ADMINISTRATION**

# Comprehensive Healthcare Inspection of Veterans Integrated Service Network 4: VA Healthcare in Pittsburgh, Pennsylvania


| CHIP Report | 22-00072-16 | November 7, 2023 |
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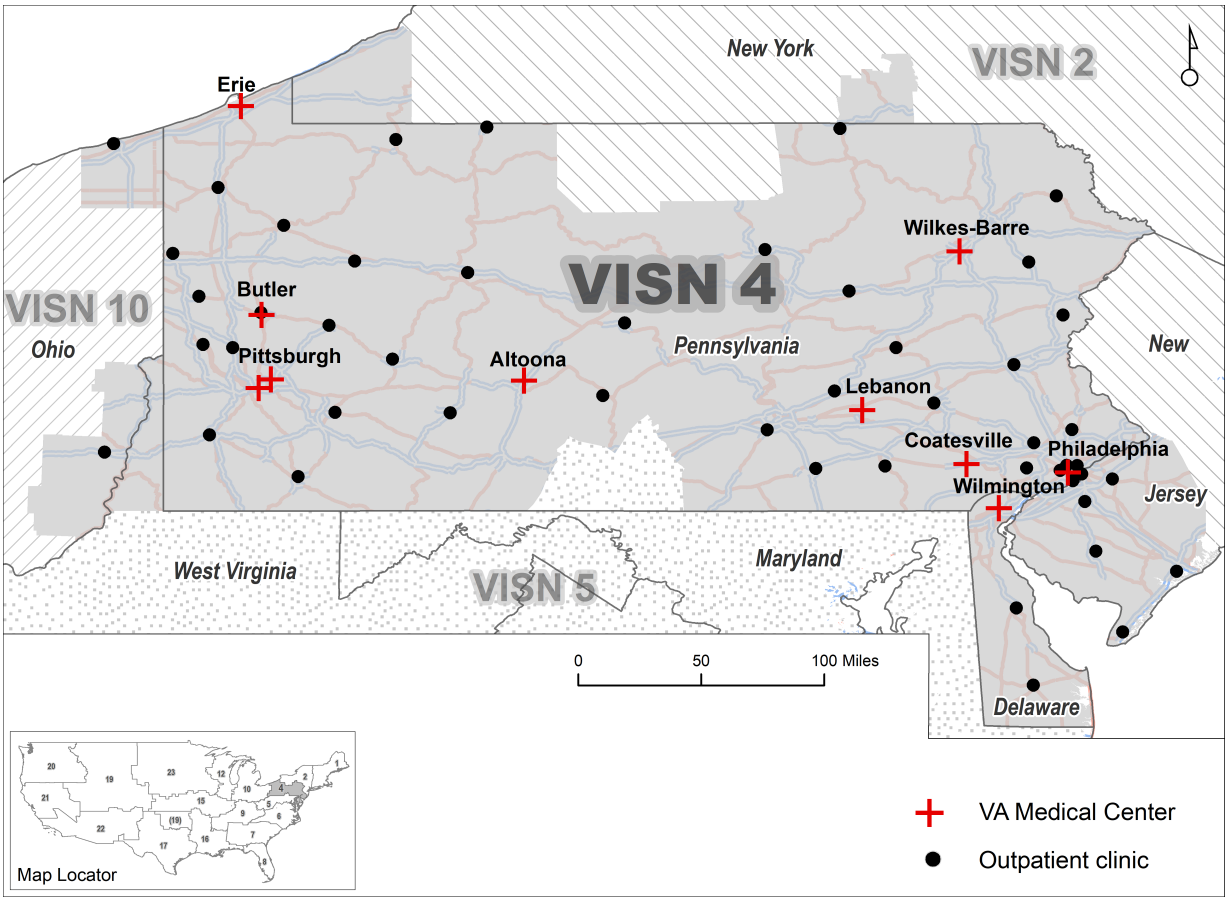


***Figure 1.*** *Veterans Integrated Service Network 4: VA Healthcare.*

*Source: Veterans Health Administration Site Tracking System (accessed June 24, 2022).*

# Abbreviations

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

# Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by Veterans Integrated Service Network (VISN) 4: VA Healthcare in Pittsburgh, Pennsylvania.[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 inspection of VISN 4: VA Healthcare during the week of June 27, 2022. The OIG also inspected the following VISN 4 facilities during the weeks of June 6, June 13, June 27, and July 11, 2022:

- Butler VA Health Care System (Pennsylvania)
- Corporal Michael J. Crescenz VA Medical Center (Philadelphia, Pennsylvania)
- Erie VA Medical Center (Pennsylvania)
- Lebanon VA Medical Center (Pennsylvania)
- Wilkes-Barre VA Medical Center (Pennsylvania)

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 4 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.

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

## Inspection Results

The OIG noted opportunities for improvement and issued two recommendations to the Network Director and Chief Medical Officer in the Medical Staff Credentialing and Privileging and Environment of Care areas of review. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 20.

### Conclusion

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

### VA Comments

The Veterans Integrated Service Network Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix C, page 22, and the responses within the body of the report for the full text of the director's comments). The OIG considers recommendations 1 and 2 closed.

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 describe leadership performance and oversight by Veterans Integrated Service Network (VISN) 4: VA Healthcare in Pittsburgh, Pennsylvania.[1] This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so they can make informed decisions to improve care.

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

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

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

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

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

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

[4] CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

# Methodology

The inspection team conducted an unannounced evaluation during the week of June 27, 2022, and examined select operations. 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 4 facilities beginning the weeks of June 6, June 13, June 27, and July 11, 2022:

- Butler VA Health Care System (HCS) (Pennsylvania)
- Corporal Michael J. Crescenz VA Medical Center (VAMC) (Philadelphia, Pennsylvania)
- Erie VAMC (Pennsylvania)
- Lebanon VAMC (Pennsylvania)
- Wilkes-Barre VAMC (Pennsylvania)

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] 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 VISN leaders complete corrective actions. The VISN 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] 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.[6] 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."[7] 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.[8]

To assess this VISN's risks, the OIG considered several 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, 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."[9]

VISN 4 consists of medical facilities and outpatient clinics in Delaware, New Jersey, New York, Ohio, Pennsylvania, and West Virginia. According to data from the VA National Center for Veterans Analysis and Statistics, VISN 4's total veteran population declined from 1,013,364 in fiscal year (FY) 2019 to 935,023 in FY 2022. VHA Support Service Center data showed an

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

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

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

[9] *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).

increase in unique patients treated from 310,744 in FY 2019, 295,566 in FY 2020, to 315,718 in FY 2021.

The VISN medical care budget was $2,762,403,754 for FY 2019; $3,406,904,446 for FY 2020; and $3,684,651,876 for FY 2021. This represented a two-year increase of over 33 percent. The Network Director reported regularly reviewing the budget and how fast leaders spent operating dollars. As of June 27, 2022, the VISN employed over 16,000 staff. This total includes a net gain of 739 employees in FY 2021 and 600 in FY 2022.

VISN 4 is divided into two markets: medical facilities in the east and medical facilities in the west. This arrangement allows integration among facilities for optimized veteran care. The VISN has a Market Collaboration Committee that meets monthly to provide direction for market-based strategies. The Chief Medical Officer (CMO) provided the following market collaboration examples across Pennsylvania:

- A urology physician assistant in Altoona worked with urology providers in Pittsburgh to coordinate care
- An ophthalmologist from Pittsburgh traveled to Erie two days a month to see patients

VISN 4 had a leadership team consisting of the Network Director, Deputy Network Director, CMO, Quality Management Officer, Chief Nursing Officer, and Chief Human Resources Officer. The executive leaders had worked together since May 2022, when the Chief Nursing Officer was assigned to the newly created position. The Network Director was assigned in September 2019. The Quality Management Officer was the longest tenured member of the leadership team, assigned in 2010.

VISN leaders identified human resources processes as the greatest organizational or enterprise risk. The Chief Human Resources Officer reported that recruitment challenges included the high cost of living in the Wilmington and Philadelphia geographic areas. Leaders also said that healthcare staffing shortages resulting from the COVID-19 pandemic prompted some private companies to offer large financial incentives to hire candidates. In response, VHA removed caps from retention bonuses; however, funds were limited to existing VISN budgets. The Chief Human Resources Officer added there were difficulties recruiting staff for certain specialties in rural areas. For example, in Wilkes-Barre, leaders made employment offers to certified registered nurse anesthetists, but a private healthcare entity subsequently offered a $70,000 sign-on bonus for these positions. The Chief Human Resources Officer discussed efforts to increase pay for nurses, advanced practice nurses, and physician assistants and to allocate funds for staff in areas with a high cost of living.

The Chief Human Resources Officer provided VISN and facility leaders with updates through the Human Capital Subcommittee on data such as time-to-hire. On June 1, 2022, the Human Capital Subcommittee approved an onboarding rapid process improvement charter to speed up

the Medical Executive Board's credentialing and privileging of licensed independent practitioners. Specific efforts included "making pay decisions and extending formal contingent offers within three business days after selection (independent of credentialing and privileging)" and convening "ad hoc meetings for facilities' executive committees of the medical staff to consider and approve new hires within ten calendar days of credentialing and privileging completion."[10]

## 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 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 (figure 2).[12]

[10] "Onboarding Rapid Process Improvement Charter, Medical Executive Board Processes, Credentialing and Privileging," VISN 4, June 1, 2022.

[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).

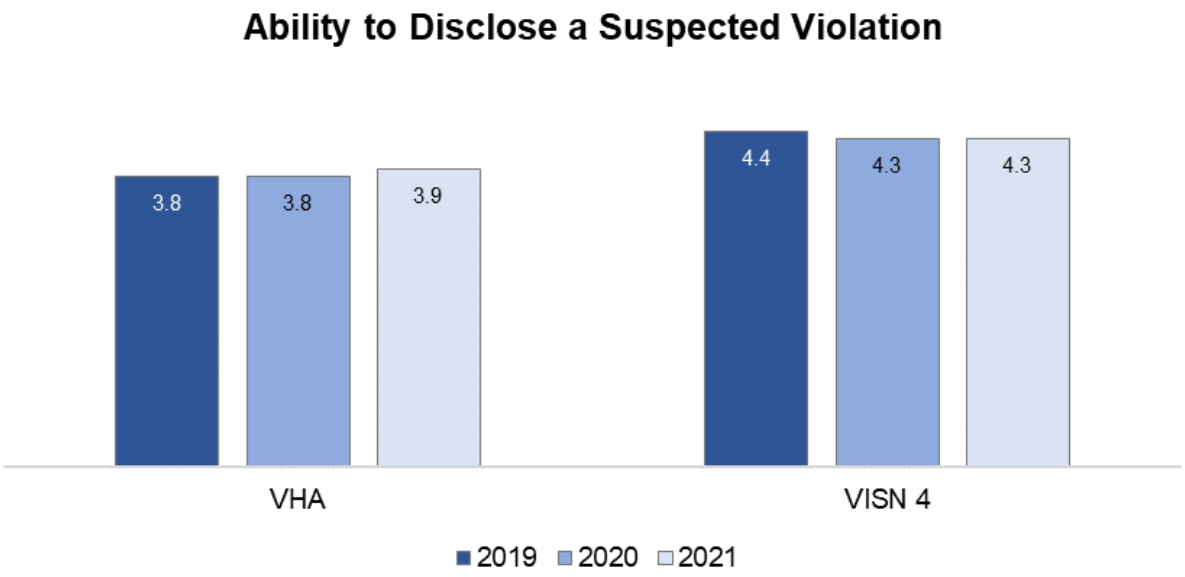


***Figure 2.*** *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

*Source: VA All Employee Survey (accessed May 24, 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.[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 VISN from FYs 2018 through 2021. Figures 3–5 provide relevant survey results for VHA and VISN 4 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 within the VISN.

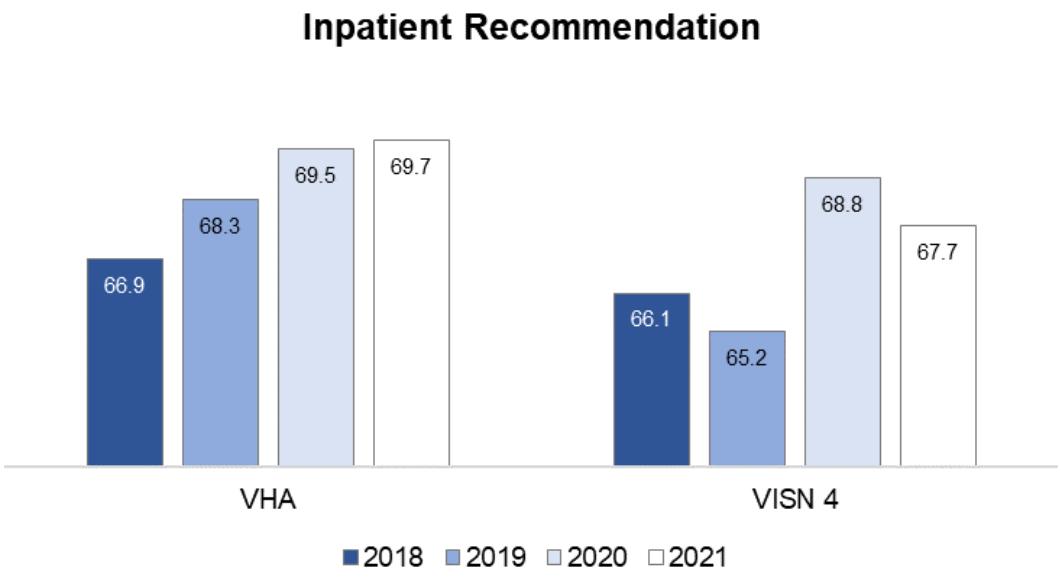


***Figure 3.*** *Survey of Healthcare Experiences of Patients (Inpatient): Would you recommend this hospital to your friends and family?*

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

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

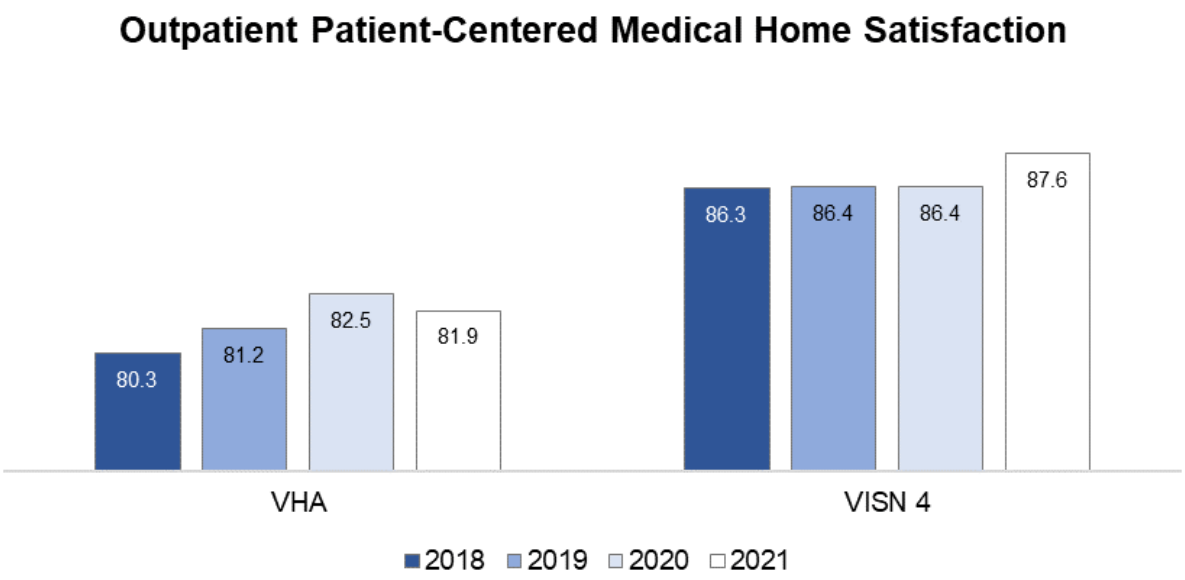


***Figure 4.*** *Survey of Healthcare Experiences of Patients (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

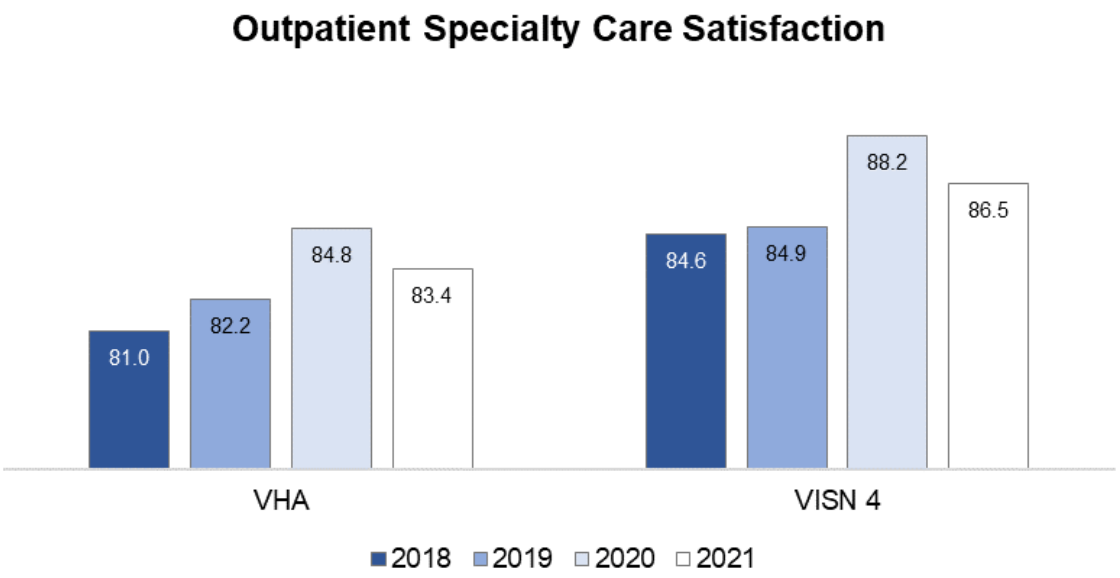


***Figure 5.*** *Survey of Healthcare Experiences of Patients (outpatient specialty care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

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

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

## Access to Care

A VA priority is ensuring timely access to the best care and benefits for the nation's veterans. VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates. VHA's goal is to provide patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[16]

To examine access to primary and mental health care within VISN 4, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 1 and 2 provide wait time statistics for

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

completed primary care and mental health appointments from January 1 through March 31, 2022.[17]

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

| Facility | Average New Patient Wait Times from Create Date (Days) |
|---|---|
| VISN 4 | 15.1 |
| Butler VA HCS (PA) | 10.9 |
| Coatesville VAMC (PA) | 9.7 |
| Corporal Michael J. Crescenz VAMC (Philadelphia, PA) | 20.9 |
| Erie VAMC (PA) | 18.6 |
| James E. Van Zandt VAMC (Altoona, PA) | 11.7 |
| Lebanon VAMC (PA) | 11.6 |
| VA Pittsburgh HCS (PA) | 17.8 |
| Wilkes-Barre VAMC (PA) | 14.5 |
| Wilmington VAMC (DE) | 17.2 |

*Source: VA Corporate Data Warehouse (accessed May 25, 2022).*

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

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

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

| Facility | Average New Patient Wait Times from Create Date (Days) |
|---|---|
| VISN 4 | 19.7 |
| Butler VA HCS (PA) | 12.6 |
| Coatesville VAMC (PA) | 10.1 |
| Corporal Michael J. Crescenz VAMC (Philadelphia, PA) | 21.5 |
| Erie VAMC (PA) | 13.6 |
| James E. Van Zandt VAMC (Altoona, PA) | 20.5 |
| Lebanon VAMC (PA) | 31.4 |
| VA Pittsburgh HCS (PA) | 17.5 |
| Wilkes-Barre VAMC (PA) | 21.8 |
| Wilmington VAMC (DE) | 16.5 |

*Source: VA Corporate Data Warehouse (accessed May 25, 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."[18] 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.[19] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[20]

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.

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

[19] 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.)

[20] 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.[21] "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."[22]

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.[23] Further, the VISN CMO is required to document a review for licensed independent practitioners with a licensure action or malpractice history.[24] 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."[25]

The OIG inspection team reviewed information for 135 physicians hired at facilities within the VISN after January 1, 2021. 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 requiring further review, inspectors examined evidence of the

- VISN Chief Human Resources Officer's review to determine whether the physician satisfies VA licensure requirements, and

[21] 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.)

[22] VHA Directive 1100.20.

[23] 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.

[24] 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.

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

- VISN CMO's review and recommendation for any licensed independent practitioner with a specific licensure or malpractice history.[26]

## Medical Staff Credentialing and Privileging Findings and Recommendations

VHA requires that the VISN CMO document a review for any licensed independent practitioner with a history of a licensure action and make a decision regarding the appropriateness of appointing the practitioner.[27] The OIG identified one physician with an adverse action warranting further review and found that VetPro lacked evidence of the VISN CMO's review and recommendation. Failure to conduct the required review could have resulted in inappropriate hiring decisions that jeopardized the quality of patient care.

The physician, who was hired in September 2021, had a license placed on probation in September 2008; the probation was terminated in November 2011. The physician also had a different state license suspended in January 2009, a motion for reconsideration denied in March 2009, and voluntary surrender of the license in May 2009. According to the CMO and the Credentialing and Privileging Officer, the hiring facility had a new credentialing staff member who was unaware of the requirement to forward the physician's information for CMO review. The CMO stated that based on the physician's information and history, there would not have been a problem with recommending appointment. Additionally, the CMO and Credentialing and Privileging Officer said they immediately began developing a plan to comply with the requirement.

## Recommendation 1

1. The Chief Medical Officer determines any additional reasons for noncompliance and reviews the credentials files and recommends VA appointments for physicians with a history of licensure action.[28]

[26] "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/.

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

[28] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Veterans Integrated Service Network concurred.

Target date for completion: Completed

Veterans Integrated Service Network response: The Chief Medical Officer reviewed the recommendations and identified ways to improve the credentialing process. Standard Operating Procedure (SOP) was developed October 25, 2022, shared with the VISN 4 Credentialing & Privileging Staff, [and] [p]resented to [the] Healthcare Delivery Committee on October 25, 2022.

The VISN 4 Credentialing and Privileging Officer will track and monitor potentially disqualifying licensure, registration, or certification [actions] from all nine VISN 4 facilities quarterly.

The numerator is the number of disqualifying licensure, registration, or certification [actions] documented in the Health Care Delivery [Committee] minutes. The denominator is the number of providers with a disqualifying licensure, registration, or certification [action].

The VISN 4 Credentialing and Privileging Officer will report the quarterly compliance rate to the Health Care Delivery Committee, chaired by the Chief Medical Officer, bi-annually, until 90% or higher compliance is achieved and maintained for 2 consecutive quarters.

Compliance monitored for 2 quarters with the following results:

FY23 Q[quarter]2: 0 of 0 = 100% Compliance
FY23 Q3: 2 of 2 = 100% Compliance

100% compliance for 2 consecutive quarters reported through the Health Care Delivery Committee in April 2023.

## Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff at healthcare facilities provide a safe, clean, and functional environment of care for veterans, their families, visitors, and employees in accordance with applicable environment of care accreditation standards and federal regulatory, VA, and VHA requirements. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[29]

To support these efforts, VHA requires VISNs to have a Comprehensive Environment of Care "oversight program with a charter."[30] 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.[31]

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

### Environment of Care Findings and Recommendations

VA requires the network director or designee to complete the Comprehensive Environment of Care compliance report survey, which "measures VISN and VA medical center (VAMC) compliance with FY21 performance metrics," and use the results to create and submit an annual VISN compliance report to the Environment of Care Committee.[32] The OIG did not find evidence the Network Director submitted an annual VISN compliance report for FY 2021 to the Environment of Care Committee, which may prevent leaders from identifying facilities' environmental issues that require VISN assistance. The Capital Asset Manager acknowledged not completing an FY 2021 VISN compliance report due to misinterpreting the requirement and believing that only the Comprehensive Environment of Care compliance report survey was needed.

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[29] 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.

[30] VHA Directive 1608.

[31] "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.

[32] Acting Assistant Under Secretary for Health for Support memo, "Fiscal Year (FY) 2021 Comprehensive Environment of Care (CEOC) Compliance Report Survey," March 10, 2022.

## Recommendation 2

2. The Network Director evaluates and determines additional reasons for noncompliance and submits a Comprehensive Environment of Care compliance report to the Environment of Care Committee annually.[33]

Veterans Integrated Service Network concurred.

Target date for completion: Completed

Veterans Integrated Service Network response: The Network Director reviewed the recommendation and did not identify any additional reason for noncompliance. The VISN 4 Comprehensive Environment of Care (CEOC) Committee co-chairs who are the VISN 4 Capital Assets Manager (CAM) and VISN 4 Deputy CAM will monitor facility performance using the CEOC tool and track submission of the compliance report to the CEOC steering committee on an annual basis.

The fiscal year (FY) 2021 report was submitted to the VHA CEOC steering committee chair by the VISN 4 CAM on September 22, 2022. The fiscal year (FY) 2022 report was submitted to the VHA CEOC steering committee chair by the VISN 4 CAM on January 13, 2023.

[33] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

## 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."[34] 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."[35]

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.[36]

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.

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

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

[36] VHA Handbook 1160.01, *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 provided two recommendations on issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this VISN. 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 two OIG recommendations that are attributable to the Network Director and Chief Medical Officer. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care. The recommendations address findings 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 Credentialing and Privileging | • The Chief Medical Officer reviews the credentials files and recommends VA appointments for physicians with a history of licensure action. |
| Environment of Care | • The Network Director submits a Comprehensive Environment of Care compliance report to the Environment of Care Committee annually. |
| Mental Health: Suicide Prevention | • None |

# Appendix B: VISN 4 Profile

The table below provides general background information for VISN 4.

**Table B.1. Profile for VISN 4**
**(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 | $2,762,403,754 | $3,406,904,446 | $3,684,651,876 |
| Number of: | | | |
| • Unique patients | 310,744 | 295,566 | 315,718 |
| • Outpatient visits | 3,681,924 | 3,389,221 | 3,850,817 |
| Unique employees§ | 11,726 | 12,048 | 12,638 |
| Type and number of operating beds: | | | |
| • Community living center | 1,014 | 1,014 | 1,014 |
| • Domiciliary | 393 | 393 | 393 |
| • Hospital | 584 | 584 | 584 |
| Average daily census: | | | |
| • Community living center | 913 | 662 | 521 |
| • Domiciliary | 349 | 219 | 158 |
| • Hospital | 348 | 298 | 310 |

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

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

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

# Appendix C: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: October 17, 2023

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

Subj: Comprehensive Healthcare Inspection of Veterans Integrated Service Network 4: VA Healthcare in Pittsburgh, Pennsylvania

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

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

1. Thank you for the opportunity to review and respond to the OIG Draft Report Comprehensive Healthcare Inspection of Veterans Integrated Service Network 4: VA Healthcare in Pittsburgh, Pennsylvania.
2. I have reviewed the findings and two recommendations. I concur with the action plans submitted and request closure.

*(Original signed by:)*

Timothy W. Liezert
Network Director, VISN 4

# 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** | Randall Snow, JD, Team Leader<br>Tishanna McCutchen, DNP, MSPH |
| **Other Contributors** | Kaitlyn Delgadillo, BSPH<br>Justin Hanlon, BAS<br>LaFonda Henry, MSN, RN<br>Cynthia Hickel, MSN, CRNA<br>Amy McCarthy, JD<br>Scott McGrath, BS<br>Joan Redding, MA<br>Larry Ross, Jr., MS<br>Caitlin Sweany-Mendez, MPH, BS<br>Yurong Tan, PhD<br>Elizabeth K. Whidden, MS, APRN |

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