US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Inspection VISN Summary Report: Evaluation of Practitioner Credentialing and Privileging for Fiscal Years 2023 to 2024

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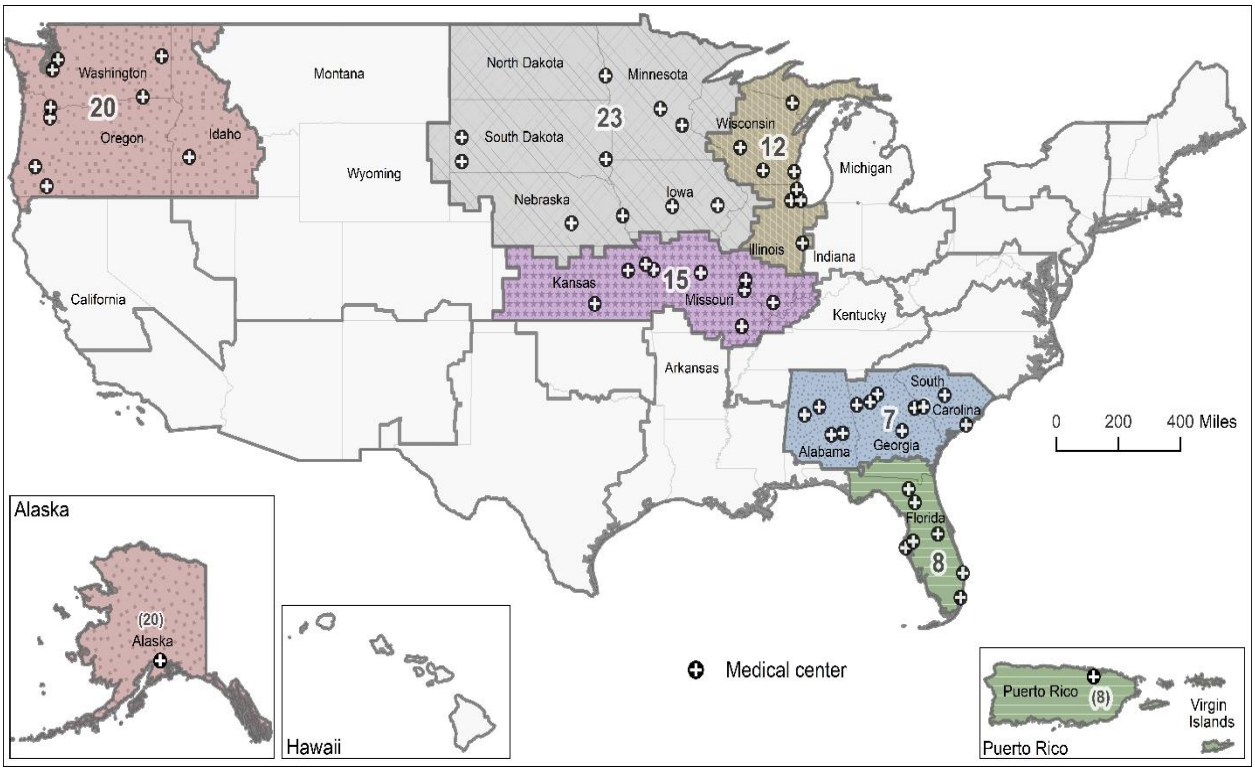

Figure 1. *VISN locations: Veterans Integrated Service Networks 7, 8, 12, 15, 20, and 23 (see appendix C for a list of facility names).*

Source: VA OIG.

Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Veterans Health Administration (VHA) administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks (VISNs). VISN leaders' oversight is key to ensuring positive patient outcomes. The OIG's VISN evaluations are one element of its overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services.

The OIG evaluated VISN-level oversight of credentialing and privileging processes at facilities within the VISNs. The OIG inspected the following VISNs from December 5, 2022, through February 14, 2024:[1]

- VISN 7, VA Southeast Network (Duluth, GA)
- VISN 8, VA Sunshine Healthcare Network (Tampa, FL)
- VISN 12, VA Great Lakes Health Care System (Westchester, IL)
- VISN 15, VA Heartland Network (Kansas City, MO)
- VISN 20, VA Northwest Health Network (Vancouver, WA)
- VISN 23, VA Midwest Health Care Network (Eagan, MN)[2]

VHA's credentialing process involves the verification of licensed independent practitioners' qualifications to provide care, such as their licensure, education, and training.[3] If certain actions had been taken against practitioners' licenses, like suspensions or probations, senior strategic business partners (previously known as human resources officers) and VISN chief human resources officers must determine whether the practitioners meet requirements for VA

[1] This date range represents the time from the first day of the oldest inspection to the completion of the most recent inspection.

[2] The six inspected VISNs cover whole or parts of 26 states and territories including: Alabama, Alaska, Arkansas, California, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Oregon, Puerto Rico, South Carolina, South Dakota, Virgin Islands, Washington, Wisconsin, and Wyoming. The OIG evaluated VISNs 7, 12, 15, 20, and 23 during fiscal year 2023, and VISN 8 during fiscal year 2024. See appendix A for the OIG's methodology and appendix B for a list of VISNs and parent facilities.

[3] VHA Directive 1100.20(2), *Credentialing of Health Care Providers,* September 15, 2021. (VHA amended this directive May 9, 2024, and September 11, 2024.)

employment.[4] Further, VISN chief medical officers must document they reviewed the previous adverse licensure action.[5] Practitioners undergo the credentialing process before being granted clinical privileges that allow them to practice at the medical facility.[6]

The privileging process involves the authorization of practitioners to provide specific healthcare services at a VHA medical facility.[7] Practitioners receive professional practice evaluations to determine their competence to receive or continue specific privileges. They receive a Focused Professional Practice Evaluation by a practitioner with equivalent specialized training and similar privileges when they are granted initial or additional privileges, and Ongoing Professional Practice Evaluations to ensure they continuously deliver quality patient care.[8] If practitioners' clinical practices pose a risk to patient safety, facility and VISN leaders are obligated to notify state licensing boards.[9] Proper credentialing and privileging is essential in ensuring practitioners deliver safe, quality health care. VHA requires VISN chief medical officers to review each facility annually and oversee credentialing and privileging processes to ensure leaders comply with VHA policies and procedures.[10]

Inspection Summary

The OIG interviewed key VISN staff and reviewed clinical and administrative processes related to practitioners' credentialing and privileging. Specifically, the OIG determined whether VISNs complied with the following requirements:

- Senior strategic business partners, VISN human resources officers, and chief medical officers review licensure information for practitioners with a history of adverse licensure actions

[4] VHA Credentialing Directive 1100.20: Standard Operating Procedure – C25 version 3*, Mandatory Reviews of Adverse Licensure, Certification, or Registration Actions*, October 2, 2020. Practitioners 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.

[5] VHA Credentialing Directive 1100.20: Standard Operating Procedure – C40 version 2*, Conducting and Documenting a Chief Medical Officer Credentials Review*, November 9, 2020.

[6] A licensed independent practitioner "is an individual permitted by law...and the VA medical facility…to provide patient care services independently, without supervision or direction, within the scope of the individual's license, and in accordance with privileges granted by the VA medical facility." 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. (The new directive has the same or similar language about privileging as the rescinded handbook.)

[7] VHA Directive 1100.21(1). See appendix B for a list of facilities within the inspected VISNs.

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

[9] "State Licensing Boards," VHA Office of Quality and Patient Safety Credentialing and Privileging, accessed February 27, 2023, https://vaww.qps.med.va.gov/AdverseActions/SLB.aspx. (This website is not publicly accessible.)

[10] VHA Handbook 1100.19; VHA Directive 1100.21(1); VHA Directive 1100.20(2).

- Practitioners with equivalent specialized training and similar privileges complete professional practice evaluations for solo and two-deep practitioners and facilities' chiefs of staff[11]
- VISN directors and privacy officers review evidence files for state licensing board reporting
- Chief medical officers review each facility annually and oversee credentialing and privileging processes

What the OIG Found

The OIG found that in VISNs 7, 8, and 15, practitioners with equivalent specialized training and similar privileges completed Ongoing Professional Practice Evaluations for solo and two-deep practitioners. However, the OIG was unable to determine whether appropriate practitioners completed evaluations in VISNs 12, 20, and 23 due to incomplete or missing information, which could delay leaders in identifying practitioners with substandard clinical practices.

Further, in VISN 8, the VA North Florida/South Georgia Veterans Health System's Chief of Staff did not have a current Ongoing Professional Practice Evaluation. The chief's evaluation was dated October 1, 2018, to September 30, 2019, but signed on February 8, 2024. The OIG also identified inconsistencies between the Chief of Staff's evaluation data and the information reported on the annual facility self-assessments for calendar years 2022 through 2024. For example, the self-assessments indicated the Chief of Staff had a completed evaluation; however, the chief's last evaluation was completed in 2019. Failure to accurately report facility self-assessment data can compromise the chief medical officer's evaluation of the credentialing and privileging program.

The OIG also found that none of the VISNs complied with VHA's state licensing board processing order or timeliness requirements for concerns about practitioners' clinical practices. Prior to reporting the practitioner to the state licensing board, VHA requires the facility director to send the evidence file to the VISN director, who then forwards it to the VISN privacy officer for review. In all six VISNs, leaders or staff sent evidence files to someone other than the VISN director, which could delay reporting.

[11] Solo practitioners are the only practitioner at a facility privileged in a particular specialty. Two-deep practitioners are the only two practitioners at a facility who have privileges in a particular specialty. Assistant Under Secretary for Health for Clinical Services/CMO [Chief Medical Officer] (11), "Revision Memo: Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," memorandum to VISN Directors (10N1-23) and VISN Chief Medical Officers (10N1-23), May 18, 2021.

What the OIG Recommended

The OIG issued four recommendations.

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures an external practitioner with equivalent specialized training and similar privileges completes solo and two-deep practitioners' professional practice evaluations in a timely manner.
2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network chief medical officers and facility senior leaders, ensures an external practitioner with equivalent specialized training and similar privileges completes Ongoing Professional Practice Evaluations of chiefs of staff in each facility in a timely manner.
3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, reviews state licensing board reporting processes at the network level to ensure compliance with Veterans Health Administration policy.
4. The Under Secretary for Health, in conjunction with the Veterans Integrated Service Network 8 Director, ensures the Chief Medical Officer oversees each facility's annual self-assessment and confirms responses reflect accurate data.

VA Comments and OIG Response

The Under Secretary for Health concurred with the recommendations and provided acceptable improvement plans (see appendixes C and D).[12] The OIG will follow up on the planned actions for the open recommendations until they are completed.

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[12] VA's responses and comments to this report were provided by individuals in leadership positions at the time of the department's formal review—December 30, 2024.

Abbreviations

FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks (VISNs). These VISNs oversee care to over nine million veterans nationwide.[1]

Veterans Integrated Service Networks

VHA established VISNs to meet local healthcare needs and increase veterans' access to care.[2] A VISN covers a geographic area defined by "patient referral patterns; numbers of beneficiaries and facilities needed to support and provide" care, as well as "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 health care system."[3]

Practitioner Credentialing and Privileging

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.[4] "Credentials are documented evidence of licensure, education, training, experience, or other qualifications."[5] VHA licensed independent practitioners (LIPs) undergo the credentialing process before being granted clinical privileges that allows them to independently provide medical care within the scope of their license.[6] When certain actions are taken against a practitioner's license, the senior strategic business partner (previously known as the human resources officer) and VISN chief

[1] "About VHA," Department of Veterans Affairs, accessed October 9, 2024, https://www.va.gov/health/aboutvha.

[2] "About VHA," Department of Veterans Affairs.

[3] *The Curious Case of the VISN Takeover: Assessing VA's Governance Structure, Hearing 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).

[4] VHA Directive 1100.20(2), *Credentialing of Health Care Providers,* September 15, 2021. (VHA amended this directive May 9, 2024, and September 11, 2024.)

[5] VHA Directive 1100.20(2).

[6] A licensed independent practitioner "is an individual permitted by law...and the VA medical facility…to provide patient care services independently, without supervision or direction, within the scope of the individual's license, and in accordance with privileges granted by the VA medical facility." 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. (The new directive has the same or similar language about privileging as the rescinded handbook.)

human resources officer must determine whether the practitioner meets licensure requirements for VA employment.[7] Further, chief medical officers are required to document a review for any practitioners with a history of an adverse licensure action.[8]

Privileging is "the process by which a VA facility authorizes a[n] LIP to independently (i.e., without supervision or restriction) provide healthcare services on a facility-specific basis."[9] Privileges need to be specific and based on the practitioner's clinical competence. Privileges are requested by the practitioner and reviewed by the responsible service chief, who then recommends approval, denial, or an amendment to the request. An executive committee of the medical staff evaluates the practitioner's credentials and service chief's recommendation and submits the final recommendation to the facility director. Practitioners are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[10]

Facility leaders monitor practitioners' performance through professional practice evaluations. Practitioners receive a Focused Professional Practice Evaluation (FPPE) when they are hired at the facility and granted initial or additional privileges, or if leaders are concerned about their ability to deliver safe patient care. Facility leaders also routinely monitor practitioners' professional practice through an Ongoing Professional Practice Evaluation (OPPE) to ensure continuous quality patient care and compliance with facility, state, national, and specialty requirements.[11]

State licensing boards evaluate practitioners' conduct and ability to practice medicine.[12] VHA has established procedures for facility and VISN leaders to report "currently appointed or separated licensed health care professionals whose behavior or clinical practice substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients" to the state licensing boards.[13]

VHA requires VISN chief medical officers to oversee credentialing and privileging processes at each facility within their network and ensure compliance with required policies and procedures.[14] Proper credentialing and privileging is essential for the delivery of quality health care, and

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[7] VHA Credentialing Directive 1100.20: Standard Operating Procedure – C25 version 3*, Mandatory Reviews of Adverse Licensure, Certification, or Registration Actions*, October 2, 2020. Practitioners 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.

[8] VHA Credentialing Directive 1100.20: Standard Operating Procedure – C40 version 2*, Conducting and Documenting a Chief Medical Officer Credentials Review*, November 9, 2020.

[9] VHA Directive 1100.21(1).

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

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

[12] "State Licensing Boards," VHA Office of Quality and Patient Safety Credentialing and Privileging, April 4, 2023, https://vaww.qps.med.va.gov/AdverseActions/SLB.aspx. (This website is not publicly accessible.)

[13] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards,* January 28, 2021.

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

leaders' oversight is key in ensuring effective processes.[15] Thus, the evaluation of VISN leaders' oversight of credentialing and privileging processes is important to ensure practitioners deliver safe, quality health care to veterans.

Inspection Elements

The OIG inspected the following six VISNs:

- VISN 7, VA Southeast Network (Duluth, GA)
- VISN 8, VA Sunshine Healthcare Network (Tampa, FL)
- VISN 12, VA Great Lakes Health Care System (Westchester, IL)
- VISN 15, VA Heartland Network (Kansas City, MO)
- VISN 20, VA Northwest Health Network (Vancouver, WA)
- VISN 23, VA Midwest Health Care Network (Eagan, MN)[16]

The OIG inspected the VISNs from December 5, 2022, through February 14, 2024. For fiscal year (FY) 2023, the OIG evaluated VISN-level oversight of practitioners' credentialing and privileging by examining whether leaders complied with selected VHA guidelines for (1) additional review of practitioners with a history of adverse licensure actions prior to VA appointment, (2) professional practice evaluations for solo and two-deep practitioners, and (3) notification to state licensing boards when practitioners' clinical practice pose a risk to patient safety.[17] For the FY 2024 review of VISN 8, the OIG discontinued its evaluation of adverse licensure actions and added a review of chief medical officers' oversight activities, including annual facility reviews, and chiefs of staff privileging processes.[18] The inspection results describe the OIG's findings related to credentialing and privileging processes that affect quality

[15] Richard E. Burney, "Oversight of Medical Care Quality: Origins and Evolution," *Journal of Medical Regulation* 101, no. 4 (2015): 8-15, https://doi.org/10.30770/2572-1852-101.4.8.

[16] The six inspected VISNs cover whole or parts of 26 states and territories including: Alabama, Alaska, Arkansas, California, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Oregon, Puerto Rico, South Carolina, South Dakota, Virgin Islands, Washington, Wisconsin, and Wyoming. The OIG evaluated VISNs 7, 12, 15, 20, and 23 during FY 2023, and VISN 8 during FY 2024. See appendix A for the OIG's methodology and appendix B for a list of VISNs and parent facilities.

[17] Solo practitioners are the only practitioner at a facility privileged in a particular specialty. Two-deep practitioners are the only two practitioners at a facility who have privileges in particular specialty. Assistant Under Secretary for Health for Clinical Services/CMO (11), "Revision Memo: Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," memorandum to VISN Directors (10N1-23) and VISN Chief Medical Officers (10N1-23), May 18, 2021.

[18] The OIG found that none of the physicians had a prior adverse licensure action that required a VISN-level review, and therefore discontinued this review in FY 2024.

of care and patient outcomes. The OIG reports findings to VHA and VISN leaders so they can make informed decisions to ensure veterans receive high-quality health care.

Inspection Results

VHA requires VISN leaders to oversee practitioner credentialing and privileging processes at each facility in their network.[19] Proper credentialing and privileging is essential for the delivery of quality health care, and leaders' oversight is key in ensuring effective processes.[20]

Adverse Licensure Actions

VHA policy requires key VISN leaders to follow certain processes when practitioners have identified adverse licensure actions.[21] The OIG reviewed licensure information for 755 physicians' from VISNs 7, 12, 15, 20, and 23 using publicly available data and VetPro.[22] The OIG found that none of the physicians had a prior adverse action that required a VISN-level review.

Solo and Two-Deep Practitioner Privileging

Since solo practitioners have unique privileges within a facility and two-deep practitioners cannot evaluate one another because of a conflict of interest, it is important for leaders to find suitable practitioners to evaluate their privilege-specific competence.[23] VHA requires that a practitioner with equivalent specialized training and similar privileges from another facility (external reviewer) complete professional practice evaluations for solo and two-deep practitioners.[24]

The OIG reviewed the most recent professional practice evaluations for select solo and two-deep practitioners across the six VISNs. The OIG noted that a practitioner with equivalent specialized training and similar privileges completed OPPEs for solo and two-deep practitioners in VISNs 7, 8, and 15. However, the OIG was unable to determine whether an appropriate practitioner

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

[20] Richard E. Burney, "Oversight of Medical Care Quality: Origins and Evolution."

[21] VHA Credentialing Directive 1100.20: Standard Operating Procedure – C25 version 3*, Mandatory Reviews of Adverse Licensure, Certification, or Registration Actions*, October 2, 2020; VHA Credentialing Directive 1100.20: Standard Operating Procedure – C40 version 2*, Conducting and Documenting a Chief Medical Officer Credentials Review*, November 9, 2020.

[22] "VetPro is VHA's mandatory credentialing software platform to document the credentialing of VHA health care providers. This system facilitates completion of a uniform, accurate, and complete credentials file." VHA Directive 1100.20(2).

[23] For example, a medical facility may have only one cardiologist (solo practitioner) or only two podiatrists (two-deep practitioners) to provide specialized care.

[24] Assistant Under Secretary for Health for Clinical Services/CMO (11), "Revision Memo: Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," memorandum.

evaluated solo and two-deep practitioners in VISNs 12, 20, and 23 due to incomplete or missing information. Lack of necessary data for reviewing a practitioner's professional activities could hamper identification of those who are not delivering appropriate and optimal care, potentially compromising patient safety.

Leaders shared an example of a challenge in coordinating an external reviewer to complete an OPPE. The VA Illiana Healthcare System's credentialing and privileging manager described requesting assistance from the VA Hines Healthcare System in February 2021 and following up on the request in June 2021 and March 2022. Then, the manager requested assistance via VHA's Credentialing and Privileging Managers' email group and guidance from the VISN Credentialing and Privileging Officer in March 2022, after unsuccessful attempts to get assistance from other network and VA facilities.

The VISN Credentialing and Privileging Officer acknowledged receiving emails from the Illiana credentialing and privileging manager and stated there was an apparent misunderstanding between staff at the two facilities. The Chief Medical Officer reported being unaware of the issue prior to the OIG site visit but following up with the chief of staff and mental health service line chief at the VA Hines Healthcare System during the week.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures an external practitioner with equivalent specialized training and similar privileges completes solo and two-deep practitioners' professional practice evaluations in a timely manner.

Facilities' Chiefs of Staff Privileging

In FY 2024, the OIG reviewed professional practice evaluations for the chiefs of staff at facilities in VISN 8.

VHA also requires an external practitioner with equivalent specialized training and similar privileges to complete the chief of staff's professional practice evaluations.[25] The OIG found that appropriate external practitioners completed evaluations for the chiefs of staff at six of the seven VISN 8 facilities.[26] However, the VA North Florida/South Georgia Veterans Health System's Chief of Staff, a radiologist, did not have a current OPPE. The chief was appointed to the position in April 2018. The chief's OPPE

[25] Assistant Under Secretary for Health for Clinical Services/CMO (11), "Revision Memo: Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," memorandum.

[26] The OIG did not review any FPPEs because all facility chiefs of staff had OPPEs as their most recent privileging action.

was dated October 1, 2018, to September 30, 2019, but signed on February 8, 2024. Failure to evaluate practitioners in a timely manner could delay leaders' identification of clinical practice trends that may jeopardize the quality of patient care.

The VISN's Chief Medical Officer and Chief Health Informatics/Specialty Care Lead (Specialty Care Lead) explained that since approximately 2020, VISN staff used the automated Professional Practice Review of Providers System for practitioner evaluations. The system assigns chart reviews to appropriate practitioners. However, the VISN Specialty Care Lead clarified that the system was not compatible with image-based specialties, such as radiology, so it did not assign chart reviews for the chief's OPPE. According to the VISN Specialty Care Lead, facility staff developed a process to track OPPEs in December 2023, and VISN staff plan to modify the Professional Practice Review of Providers System to include radiology practitioners in its automated selection process.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network chief medical officers and facility senior leaders, ensures an external practitioner with equivalent specialized training and similar privileges completes Ongoing Professional Practice Evaluations of chiefs of staff in each facility in a timely manner.

State Licensing Board Reporting

VA medical facility leaders are obligated to notify the state licensing board if they identify a reportable concern about a practitioner's behavior or clinical practice that could negatively affect patient safety.[27] The facility director sends a complete evidence file to the VISN director, who forwards the evidence file to the VISN privacy officer within three business days of receipt. The VISN privacy officer must review the evidence file within seven business days of receipt and return it to the facility.[28] The state licensing board reporting process consists of five stages.

[27] "State Licensing Boards," VHA Office of Quality and Patient Safety Credentialing and Privileging.
[28] VHA Directive 1100.18.

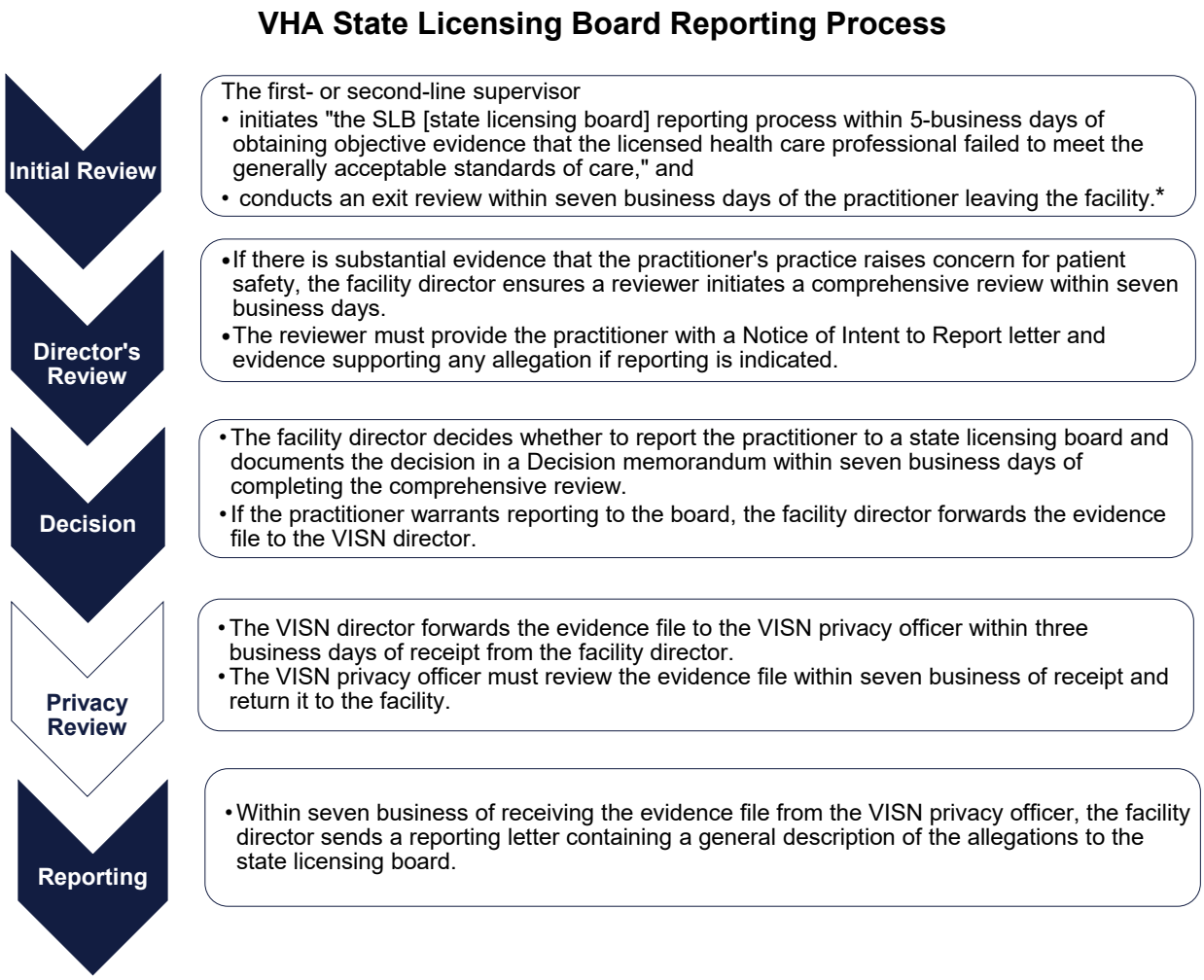

Figure 2. *VHA state licensing board reporting process.*
**VHA Directive 1100.18.*
Source: VHA Directive 1100.18.

The OIG found that none of the VISN leaders consistently complied with state licensing board processing order or timeliness requirements. In all six VISNs, facility leaders or administrative staff sent evidence files to someone other than the VISN director. Failure to ensure that all necessary parties receive the evidence file in a timely manner could hinder communication among leaders regarding practitioners who may have delivered substandard care at a facility. Leaders attributed the noncompliance to a chief medical officer, network accreditation coordinator, and quality management staff being involved in evidence file correspondence and misunderstanding VHA policy; a privacy officer having competing priorities; and VISN directors deviating from the process to increase efficiency.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, reviews state licensing board reporting processes at the network level to ensure compliance with Veterans Health Administration policy.

VISN Chief Medical Officer Oversight Activities

In FY 2024, the OIG evaluated the VISN 8 Chief Medical Officer's oversight activities, including annual reviews of each facility's credentialing processes.

VHA requires VISN chief medical officers to oversee the credentialing and privileging process at all network facilities.[29] Chief medical officers must complete an annual review of credentialing processes at each facility to ensure compliance with required policies and procedures, ensure new practitioners are credentialed, and initiate corrective actions if necessary. VHA also requires the chief medical officers to establish a VISN-wide process for coordinating appropriate external reviewers for professional practice evaluations.[30]

The OIG found that the VISN 8 Chief Medical Officer complied with the above requirements but identified an issue with one facility's annual credentialing and privileging self-assessments. A facility interdisciplinary team must complete an annual credentialing and privileging self-assessment so VISN leaders can monitor compliance with VHA's requirements.[31] The OIG noted some inconsistencies between the chief of staff's professional practice evaluation data and information reported on VISN 8's VA North Florida/South Georgia Veterans Health System's 2022–2024 annual facility self-assessments. The interdisciplinary team's responses to questions about OPPEs, including for the chief of staff, indicated "yes" despite missing information to support the responses (see table 1).

[29] VHA Handbook 1100.19; VHA Directive 1100.21(1); VHA Directive 1100.20(2).

[30] VHA Directive 1100.20(2); Assistant Under Secretary for Health for Clinical Services/CMO (11), "Revision Memo: Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," memorandum.

[31] VHA Credentialing Directive 1100.20: Standard Operating Procedure – C24 version 3, *Credentialing and Privileging Program Facility Self-Assessment,* September 16, 2020.

Table 1. VA North Florida/South Georgia Veterans Health System Selected Annual Facility Self-Assessment Questions with Affirmative Responses (Calendar Years 2022–2024)

Year	Question Number	Facility Self-Assessment Questions
2022	27	"For solo practitioners, two-deep practitioners, and the Chief of Staff, were the FPPE and OPPE reviews completed by another LIP at an external facility with equivalent specialized training and similar or higher privileges (or scope of practice)?"
	28	"If the FPPE or OPPE review was for the Chief of Staff, were the results of the clinical review returned to the applicable clinical service chief?"
2023	28	"For solo practitioners, two-deep practitioners, and the Chief of Staff, were the FPPE and OPPE reviews completed by another LIP at an external facility with equivalent specialized training and similar or higher privileges (or scope of practice)?"
	29	"For Chief of Staff FPPE or OPPE, were the results of the clinical review returned to the applicable clinical service chief?"
2024	32	"Was the OPPE completed at its required frequency?"
	33	"Were OPPE results communicated to the practitioner?"

Source: VISN Specialty Care Lead.

As noted previously, the facility's chief of staff had not had an OPPE completed since calendar year 2019, so affirmative responses to questions about chief of staff's evaluations were inaccurate. Failure to document accurate information could impede the chief medical officer's assessment of the facility's credentialing and privileging program. During an interview with the Chief Medical Officer and VISN Specialty Care Lead, the lead reported being unaware of the discrepancies but will review and address them with appropriate staff.

Recommendation 4

4. The Under Secretary for Health, in conjunction with the Veterans Integrated Service Network 8 Director, ensures the Chief Medical Officer oversees each facility's annual self-assessment and confirms responses reflect accurate data.

Conclusion

The OIG evaluated VISN-level oversight of credentialing and privileging processes at facilities within the VISNs and provided recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

Appendix A: Methodology

The OIG initiated unannounced inspections at six VISNs from December 2022 through February 2024: VISN 7, VA Southeast Network (Duluth, GA); VISN 8, VA Sunshine Healthcare Network (Tampa, FL); VISN 12, VA Great Lakes Health Care System (Westchester, IL); VISN 15, VA Heartland Network (Kansas City, MO); VISN 20, VA Northwest Health Network (Vancouver, WA); and VISN 23, VA Midwest Health Care Network (Eagan, MN).[1] The resulting report describes OIG's examination of key clinical and administrative processes that affect quality of care and patient outcomes. The OIG reports findings to VHA leaders so they can make informed decisions to improve care.

The team reviewed VHA policies and standard operating procedures; interviewed VISN leaders and staff to discuss administrative processes; reviewed documents and internal OIG data; and discussed reasons for noncompliance.[2] During the site visits, the OIG did not receive any complaints beyond the scope of the inspections 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.[3] 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 inspections in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.[4]

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions.

[1] The OIG team's site visits began on the following dates: VISN 7—April 3, 2023; VISN 8—February 5, 2024; VISN 12—June 5, 2023; VISN 15—February 6, 2023; VISN 20—July 10, 2023; and VISN 23—December 5, 2022.

[2] Documents reviewed included VHA handbooks and directives; standard operating procedures, and memorandums; VISN policies, organizational charts, and staffing data; agendas, and meeting minutes; annual reports, and VISN-maintained databases.

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

[4] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

Appendix B: VA Facilities within the Inspected VISNs

Table B.1. VA Facilities within the Inspected VISNs

VISN Number	Facility Names	Location
7	Birmingham VA HCS	Birmingham, AL
	Columbia VA HCS	Columbia, SC
	Ralph H. Johnson VA HCS	Charleston, SC
	VA Atlanta HCS*	Decatur, GA
	VA Augusta HCS †	Augusta, GA
	VA Central Alabama HCS	Montgomery, AL Tuskegee, AL
	VA Dublin HCS	Dublin, GA
	VA Tuscaloosa HCS	Tuscaloosa, AL
8	Bay Pines VA HCS	Bay Pines, FL
	Miami VA HCS	Miami, FL
	VA Caribbean HCS	San Juan, PR
	VA North Florida/South Georgia Veterans Health System	Gainesville, FL Lake City, FL
	VA Orlando HCS	Orlando, FL
	VA Tampa HCS	Tampa, FL
	West Palm Beach VA HCS	West Palm Beach, FL
12	Lovell Federal HCS	North Chicago, IL
	Tomah VA HCS	Tomah, WI
	VA Chicago HCS	Chicago, IL
	VA Hines HCS	Hines, IL
	VA Illiana HCS	Danville, IL
	VA Iron Mountain HCS	Iron Mountain, MI
	VA Milwaukee HCS	Milwaukee, WI
	William S. Middleton Memorial Veterans' Hospital and Clinics	Madison, WI
15	VA Columbia Missouri HCS	Columbia, MO
	VA Eastern Kansas HCS	Topeka, KS Leavenworth, KS
	VA Kansas City HCS	Kansas City, MO
	VA Marion HCS	Marion, IL
	VA Poplar Bluff HCS	Poplar Buff, MO

VISN Number	Facility Names	Location
	VA St. Louis HCS‡	St. Louis, MO
	VA Wichita HCS	Wichita, KS
20	Alaska VA HCS	Anchorage, AK
	Jonathan M. Wainwright Memorial VA Medical Center	Walla Walla, WA
	Roseburg VA HCS	Roseburg, OR
	VA Boise HCS	Boise, ID
	VA Portland HCS	Portland, OR Vancouver, WA
	VA Puget Sound HCS	Seattle, WA Tacoma, WA
	VA Spokane HCS	Spokane, WA
	VA Southern Oregon HCS	White City, OR
23	Fargo VA HCS	Fargo, ND
	Minneapolis VA HCS	Minneapolis, MN
	St. Cloud VA HCS	St. Cloud, MN
	VA Black Hills HCS	Fort Meade, SD Hot Springs, SD
	VA Central Iowa HCS	Des Moines, IA
	VA Iowa City HCS	Iowa City, IA
	VA Nebraska-Western Iowa HCS	Grand Island, NE Omaha, NE
	VA Sioux Falls HCS	Sioux Falls, SD

Source: VA OIG.

HCS = Health Care System or Healthcare System

*****VA Atlanta HCS includes the Joseph Maxwell Cleland Atlanta VA Medical Center, Fort McPherson VA Clinic, and Trinka Davis Veterans Village as shown in figure 1.*

† *VA Augusta Health Care System includes the Augusta VA Medical Center – Uptown and Charlie Norwood VA Medical Center as shown in figure 1.*

‡ *VA St. Louis HCS includes the John J. Cochran Veterans Hospital and St. Louis VA Medical Center-Jefferson Barracks as shown in figure 1.*

Appendix C: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: December 30, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Healthcare Inspection Veterans Integrated Service Network (VISN) Summary Report: Evaluation of Practitioner Credentialing and Privileging for Fiscal Years 2023 to 2024 (VIEWS 12444766)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's Healthcare Inspection VISN Summary Report on practitioner credentialing and privileging activities. VHA concurs with all four recommendations and submits the attached action plan.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vha10oicgoalaction@va.gov.

(Original signed by:)

Shereef Elnahal M.D., MBA

Appendix D: VA Responses

Recommendation 1

The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures an external practitioner with equivalent specialized training and similar privileges completes solo and two-deep practitioners' professional practice evaluations in a timely manner.

__X__Concur

_____Nonconcur

Target Completion Date: April 30, 2025

VHA Comments

The Veterans Health Administration (VHA) Credentialing and Privileging Office will analyze compliance data and develop a strategy to address the areas of non-compliance in collaboration with stakeholders to ensure an external practitioner with equivalent specialized training and similar privileges completes solo and two-deep practitioners' professional practice evaluations in a timely manner.

Recommendation 2

The Under Secretary for Health, in conjunction with Veterans Integrated Service Network chief medical officers and facility senior leaders, ensures an external practitioner with equivalent specialized training and similar privileges completes Ongoing Professional Practice Evaluations of chiefs of staff in each facility in a timely manner.

__X__Concur

_____Nonconcur

Target Completion Date: April 30, 2025

VHA Comments

The Veterans Health Administration (VHA) Credentialing and Privileging Office will analyze compliance data and develop an educational strategy to address the areas of non-compliance in collaboration with stakeholders to ensure an external practitioner with equivalent specialized training and similar privileges completes Ongoing Professional Practice Evaluations for chiefs of staff in a timely manner.

Recommendation 3

The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors, reviews state licensing board reporting processes at the network level to ensure compliance with Veterans Health Administration policy.

__X__Concur

_____Nonconcur

Target Completion Date: April 30, 2025

VHA Comments

The Veterans Health Administration (VHA) Credentialing and Privileging Office will reassess applicable policies and develop an educational strategy to address the areas of non-compliance in collaboration with stakeholders for state licensing board reporting processes.

Recommendation 4

The Under Secretary for Health, in conjunction with the Veterans Integrated Service Network 8 Director, ensures the Chief Medical Officer oversees each facility's annual self-assessment and confirms responses reflect accurate data.

__X__Concur

_____Nonconcur

Target Completion Date: April 30, 2025

VHA Comments

The Veterans Health Administration (VHA) Credentialing and Privileging Office will partner with the Veterans Integrated Service Network 8 leadership to provide oversight of the 2025 annual self-assessment and confirm accurate data.

OIG Contact and Staff Acknowledgments

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