



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Descriptive Analysis of Select
Performance Indicators at
Two Healthcare Facilities in
the Same Veterans
Integrated Service Network



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Executive Summary

As part of the Office of Inspector General's (OIG) ongoing efforts to enhance its oversight reports, the Office of Healthcare Inspections is exploring different ways to understand and evaluate systems and processes in facilities and identify opportunities for improvement. To this end, the OIG conducted a review of select aspects of operations and performance at two Veterans Health Administration (VHA) facilities in the same Veterans Integrated Service Network (VISN X) that historically ranged from relatively low performing (Facility A) to relatively high performing (Facility B).¹

Although the OIG typically identifies the facilities that are the subject of inspection reports, unless the demands of the Privacy Act counsel against it, this report does not do so. The OIG has previously published inspection reports, including hotline inspections and Comprehensive Healthcare Inspection Program reports, about each of the facilities discussed in this report that do identify the facilities. However, the purpose of this report is not to identify specific failures or challenges faced by either facility. Rather, the intent of this report is to identify and compare characteristics of a relatively high-performing facility against those of a relatively low-performing facility to draw lessons about how lower-performing facilities may improve the quality of medical care. The purpose of affording confidentiality to quality assurance records is to ensure candor and reliability in the process.² The OIG intends for this review to serve as another tool to help VHA and VISN leaders identify strategies for improvement when facilities under their purview experience performance challenges similar to Facility A.

An OIG analysis of VHA performance and other quality data revealed that Facility A was generally a below-average or lower performer in comparison to other VHA facilities nationwide from October 1, 2017, through September 30, 2020. An internal OIG risk-stratification model categorized Facility A as either a high risk or on a watch list from January 2019 through September 2020. In calendar years 2019–2020, the Office of Healthcare Inspections published six reports about health care and processes, among other issues, at Facility A, and made a total of 103 recommendations for improvement.³

¹ Facilities A and B provide primary, tertiary, and long-term care in multiple clinical areas and specialties, and are classified as Level 1a–High Complexity facilities. VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and Level 3 facilities are the least complex.

² S. Rep. No. 96-876, at 31 (1980); 38 USC § 5705.

³ The Office of Healthcare Inspections published one additional review for Facility A during calendar year 2021 through August 2021, which yielded a report with three recommendations.

An OIG analysis of Strategic Analytics for Improvement and Learning (SAIL) performance and other quality data revealed that Facility B was generally an above-average performer in comparison to other VHA facilities nationwide from October 1, 2017, to December 31, 2018, and became a higher performer from January 1, 2019, through September 30, 2020. The Office of Healthcare Inspections published one routine review during the calendar years 2019–2020, which yielded a report with 13 recommendations.⁴

The intent of this report is not to suggest that Facility A is failing to provide quality care to the veterans it serves, but rather to identify the underlying and sometimes abstract factors potentially contributing to lower performance. The OIG considers this type of review to be another tool for VHA and VISN leaders to study and consider when facilities under their purview experience similar performance challenges to Facility A.

In general, the OIG found that both facilities approached and addressed many patient safety and quality of care issues similarly, following VHA guidance and using VHA tools. However, after an in-depth review of data, policies, governance structures, and leadership interviews, the OIG found several factors directly shaped each facility's ability to focus, prioritize, and accomplish progressively higher performance. The two broad factors were: (1) leadership and (2) integration of an effective quality, safety and value (QSV) program and of high-reliability organization (HRO) principles.⁵ The VISN, as well as VHA central office-level leaders, should monitor these areas and employ interventions and mitigation strategies as appropriate.

The OIG also determined that facility culture and human resource-related considerations affected operations and performance. While the VISN and VHA have existing operational processes that impact both of these areas, it would be useful to explore the underlying themes that may reveal additional opportunities for improvement.

Leadership

Leadership, including stability, unity, and succession planning, is foundational to successful hospital operations by providing a level of constancy and consistency necessary to promote trust,

⁴ The Office of Healthcare Inspections published two additional reviews for Facility B during the calendar year 2021 through August 2021, which yielded two reports with eight recommendations to the Facility B director.

⁵ HROs are organizations that have been shown to experience fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments. In February 2019, VHA rolled out a new initiative outlining steps toward becoming an HRO. VHA selected Facility B as a lead, or cohort 1, site for HRO implementation and has received significant VHA training and support in HRO-related efforts. Facility A, as a cohort 3 site, is in the early stages of HRO implementation and is awaiting the intensive VHA training and support already received by Facility B. The path to achieving Zero Harm in a high-risk environment relies on the strength and interconnectedness of QSV and patient safety processes, HRO integration, and reporting and oversight.

productivity, and innovation.⁶ Further, effective hospital performance depends on how well leaders work together, integrate different skills, and consider varied leadership perspectives. The executive leadership teams (ELTs) at both facilities followed a Pentad model, which consists of the Facility Director, Chief of Staff, Assistant Director, Associate Director, and Assistant Director for Patient Care Services. While not an ELT position, the OIG included the QSV chief in the review given the critical nature of this position in hospital operations and performance.

Over the years, Facility A has experienced ongoing turnover of its leadership team, with the current Facility Director of four years (one year in an “acting” capacity and three years in the permanent position) reportedly being the longest serving director in 15 years.⁷ A leader estimated there had been 10 acting or permanent facility directors in the past 10 years, and another leader estimated there had been “at least” 70 ELT members in the past 10 years. Further, the QSV chief position at Facility A has been covered by multiple detailees during a time when VHA has been increasingly emphasizing integration of the HRO model and alignment within the organizational structure. While Facility A leaders repeatedly identified the need for permanency in leadership positions, the OIG noted that none of the ELT members suggested succession planning was a possible means to achieve this goal. Succession planning is vital to ensuring there are highly qualified people in key positions “today and in the future,” and provides operational stability and consistency in a highly complex, high-risk field.

In contrast, the Facility B Director told the OIG of inheriting a stable leadership team, including the QSV chief. Despite several recent changes to the ELT, the long tenures of the Facility Director (7.5 years as of August 2020) and previous Chief of Staff (20 years before retiring in August 2020) contributed to an environment that supported consistent direction and set the stage for higher performance over time. The minimal use of temporarily assigned employees at Facility B’s ELT level, as well as the QSV chief, provided compelling evidence of the impact of leadership team stability and effective succession-planning practices. Specifically, several leaders were “home grown,” occupying deputy-level positions immediately preceding elevation to their current positions, and several ELT members commented about the strength of the service chiefs, who supported seamless operations when there was leadership turnover.

The OIG found that ongoing turnover in Facility A leadership over the years has hampered leaders’ ability to consistently focus on team and trust building, as well as succession planning for key positions. Although Facility A leaders and others the OIG interviewed expressed

⁶ VA Directive 5002, *Department of Veterans Affairs (VA) Workforce and Succession Planning*, January 15, 2003, describes workforce and succession planning as “the continuous management process of determining the kinds of employees and infrastructure required to accomplish VA’s mission and the development and implementation of strategies to meet those needs.”

⁷ Turnover is the number of staff who have left the organization, typically given as a percentage in the last 12 months. VHA Research Series: *The Business Case for Work Force Stability 2002*, accessed August 20, 2020, <https://www.leg.state.nv.us/Session/72nd2003/Interim/StatCom/HealthCareDelivery/exhibits/11617K.pdf>.

enthusiasm about the stability and direction of the current ELT, the many years leading to this point have been marked by low employee satisfaction and ongoing lower performance in relation to multiple quality domains. Given the known and long-standing challenges and other circumstances surrounding Facility A, the OIG believes that VISN X and potentially VHA leaders could have intervened earlier with resources aimed at supporting local leadership and ultimately improving performance.

QSV Program and HRO Integration

A strong facility QSV program and effective integration of HRO principles are interdependent, providing the organizational infrastructure that supports and formalizes quality, safety, and oversight expectations and activities. QSV programs across VHA are responsible for multiple functional areas including quality management, patient safety, business compliance, and systems redesign.

In October 2019, VHA rescinded Directive 1026, *Enterprise Framework for Quality, Safety, and Value*, and in December 2019, issued VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*. The rescission memo stated that new guidelines and a national directive to support quality and safety programs would be developed; however, as of May 2021, that had not occurred. The issuance of national guidelines could clarify expectations about how and where some traditional QSV functions fit into the overall organizational and governance structure.

The QSV program in VHA facilities is a cornerstone of hospital operations. Specifically, when a QSV program is robust, that facility is positioned to perform well in relation to quality of care and patient safety. Conversely, weaknesses in a QSV program are often associated with underperformance or outright failures in quality of care and patient safety. Therefore, the strength of QSV leadership and the adequacy of staffing for key quality and patient safety functions are critical. VHA has not prescribed a baseline level of staffing to support various QSV program areas, leaving facilities to make their own staffing determinations. Facility A's organizational chart included approximately 30 more positions than Facility B's to support similar quality- or safety-related activities.⁸ While some of Facility A's new positions appeared to be specific to a newly integrated Office of High Reliability/Quality, Safety and Value, and thus were tasked with developing processes supportive of HRO integration, Facility B's processes and HRO integration were in fact further developed and therefore may not have required the same level of "developmental" staffing support as Facility A's to accomplish the

⁸ An approved organizational chart for Facility A's newly integrated Office of High Reliability/Quality, Safety and Value, January 6, 2021, greatly expanded staffing to 48 full-time equivalent employees, and included new roles such as an associate director for HRO and QSV; chief of quality operations; additional patient safety and clinical risk managers; section chiefs for patient safety, risk management, and quality analytics; and additional quality consultants, auditors, and investigators.

tasks. Nevertheless, the dramatic difference in QSV staffing at the two facilities raises the possibility that redundancies and other inefficiencies may exist in Facility A's QSV staffing model. The VISN X Quality Management Officer was unaware of Facility A's new (January 2021) QSV organizational chart and could not comment on why some QSV programs with substantially fewer staff were successful. VISN Quality Management Officers are responsible for overseeing the VISN's overall quality management program to ensure consistency with systemwide goals and strategic objectives. Therefore, VISN Quality Management Officers should be knowledgeable about QSV operations at their respective VISNs.

To assess each facility's QSV program, the OIG team reviewed several processes and data points that provide insight into a program's strength and oversight, including patient safety event reporting and analysis, Healthcare Failure Mode and Effect Analysis (HFMEA), and Root Cause Analysis (RCA). The OIG also evaluated select aspects of peer review and credentialing and privileging. The OIG found that while Facility A included the required information in reviews of patient safety event reports, analysis and action planning tended to lack detail regarding circumstances surrounding the event, as well as mitigation efforts and actions taken to avoid future events. In contrast, Facility B's reviews consistently included details about reported events, contributing factors, lessons learned, and actions taken.

Both Facilities A and B completed the required annual HFMEAs that included actions, target dates for completion, and status updates, and both received high-level recognition from VHA's National Center for Patient Safety in fiscal years 2018 and 2019 for RCA completion. In relation to peer review and credentialing and privileging, the OIG determined that in general, Facilities A and B both had solid processes and tracking systems to identify and address provider-related practice deficits and credentialing and privileging discrepancies.

As part of its modernization efforts and with a goal to maximize patient safety and minimize harm, VHA rolled out a new initiative in February 2019 outlining definitive steps toward becoming an HRO. Measuring the impact and effectiveness of HRO integration into a facility's governance and culture can be challenging. The OIG evaluated a variety of objective operational and organizational data to understand how each facility was complying with basic committee structures, reporting requirements, documentation, and follow-up activities when patient safety issues were brought forward.⁹ The OIG identified opportunities for Facility A to enhance communication and the flow of information by improving the quality and content of meeting minutes. For example, the Executive Leadership Board minutes reviewed did not consistently document an adequate description, analysis, or discussion of the issues, or document action items and follow-through reflecting action completion. The OIG also determined that efforts to align

⁹ VHA and facilities' policies require integration across the organizational structure to promote the exchange and flow of quality-related data and avoid organizational silos. This organizational integration is addressed, in part, through a formal committee reporting structure headed by an executive leadership body.

Facility A's governance structure around systems redesign and the HRO framework had, while progressing, been slow to take shape. For example, reports submitted by the QSV and Initiative Council for October 24, 2019, to November 30, 2020, continued to present the same standard topics, in the same format, without mention of systems redesign or HRO activities.

The OIG found Facility B's meeting minutes reflected topics that were current and relevant based on ongoing national issues. Overall, documentation of discussions was detailed, and action items were tracked to completion. HRO principles were integrated into operations and reporting, and HRO activities were documented and discussed at the Senior Executive Council level.

The OIG recognizes that meeting minute documentation and committee structure are not pillars of an HRO; however, they can give insight into a facility's progress toward a patient-centric cultural redesign.

Facility Culture

Facility culture is the "set of behaviors, beliefs, policies, and actions that are regularly implemented within a particular setting," and the collective elements of facility culture affect the efficiency and timeliness of how the day-to-day work gets done. The OIG discussed with leaders and managers how they perceived the overall culture at their respective facilities, as well as how they approached key characteristics of organizational culture, specifically communication and Staff Engagement, Problem Identification and Resolution Processes, and Resilience and Innovation.

In OIG discussions with Facility A leaders over the past several years, there was a general consensus that the facility had been plagued by pockets of employees who were resistant (to change) and negative (in their interactions). According to several leaders, Facility A had a history of nonaccountability in certain areas, and Facility A's All Employee Survey (AES) Best Places to Work data for 2017–2020 reflected performance consistently below the VHA-wide average. However, several current leaders asserted that the culture was improving, stating, "It looks like a different place," and the "culture is much healthier [than it used to be]."

The culture at Facility B was generally described by leaders and managers as one of high expectations and accountability, with "a vast majority" of staff committed to the mission to provide the best patient care possible. Facility B's AES Best Places to Work data for 2017–2020 reflected scores that were generally consistent with the VHA-wide average.

Communication is pivotal to workforce engagement, and staff members and leaders across both Facilities A and B reported similar communication processes and activities such as Town Hall meetings, email updates, and regular huddles. In 2020, Facility A created an internal communication specialist position with the incumbent responsible for, among other things, information flow and management of assignments between offices. Facilities A and B told the

OIG they viewed communication as an ongoing improvement opportunity at their respective facilities.

In a complex, high-risk healthcare environment, organizations must be efficient problem solvers. The HRO principle of **Deference to Expertise** states that on-the-ground subject matter experts are essential for urgent situational assessments and that decisions about how to deal with problems are made by those experts. Interviews reflected that leaders across both facilities believed that they sought input and participation from frontline staff and that they empowered employees to problem solve and bring improvement ideas forward. They also described similar approaches to ensure staff inclusion in these activities.

The HRO principle of **Commitment to Resilience** centers around an organization's ability to cope with unexpected events and innovate solutions "within a dynamic environment." The OIG learned through interviews that both facilities approached and managed the significant challenges related to COVID-19, which would meet most people's definition of an unexpected event, in similar ways.¹⁰ Notably, though, Facility A's Director told the OIG that Facility A staff feared taking risks, and this type of risk aversion can limit a facility's growth.¹¹ Nevertheless, Facility A leaders reported encouraging and supporting innovative ideas.

Facility B leaders were positive about the level of innovation and risk taking, with one ELT member commenting about "how nimble" the staff were when changes were in the interest of patients.

Human Resource Management

The OIG identified two important human resource-related factors that contribute to an organization's ability to provide services efficiently, effectively, and safely. Those factors were the strength of human resource staffing and processes and the degree of registered nurse turnover.

Human resource staff at both facilities reported shortages of facility-level human resource personnel to support recruitment and placement activities. Further, each facility reported using similar recruitment and hiring processes and incentives to address hiring challenges.

VHA data reflected an increase in Facility A's registered nurse turnover rate for the 12 months beginning in June 2019. Specifically, from June to July 2019, registered nurse turnover increased

¹⁰ World Health Organization, *WHO Director-General's Opening Remarks at the Media Briefing on COVID-19, 11 March 2020*, accessed November 4, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. VHA Public Health, *Novel Coronavirus Disease (COVID-19)*, accessed on August 5, 2020, <https://www.publichealth.va.gov/n-coronavirus/index.asp>.

¹¹ Facility A's Director described the *fear of risk taking* as staff being reluctant to take actions or implement processes outside of a rigid, by-the-book approach, and attributed this fear to the high level of scrutiny by the OIG and staff perceptions that taking risks could result in disciplinary action.

from 6.7 percent to 12.3 percent and remained above 10 percent through June 2020. Facility A's Acting Associate Director for Patient Care Services reported implementing a variety of actions to address nursing personnel-related issues. It did not appear to the OIG, however, that Facility A broadly employed a shared governance structure, which allows nursing staff to work collaboratively and share responsibility for making decisions that affect their nursing practice.

The Assistant Human Resource Manager told the OIG that Facility B did not have difficulty hiring registered nurses, and the OIG's review of VHA data revealed that Facility B's registered nurse turnover rate had largely remained steady over the past several years, ranging from 4.5 percent to 6.8 percent. Facility B used a shared nursing governance structure.

Key Take-Away from the Review

Most facilities can and should identify, evaluate, and address opportunities to improve patient care and safety within their organizations. However, some VHA facilities, such as Facility A, that have been chronic relatively lower performers, have experienced high leadership turnover and challenges recruiting permanent, high-caliber managers and leaders. These challenged facilities may benefit from more proactive VISN support that begins with a careful examination of leadership, the strength of the QSV program, and the integration of HRO principles.

Suggestions for VISN Consideration

In that this was not a traditional compliance or quality review, the OIG did not make formal recommendations. Rather, the OIG identified opportunities for VISNs to provide meaningful and timely assistance to both struggling and better performing facilities and provided eight suggestions for VISNs to consider. Those suggestions related to mentors; external evaluation and development teams, leadership assignment, development and succession planning; quality and safety-related policy updates and staffing methodology; and meeting minute documentation.

Comments

The Acting Under Secretary for Health reviewed the report (see appendix D for the Acting Under Secretary for Health's comments), and the OIG briefed VHA, VISN X, and Facility A and B leaders about the contents of the report.



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Abbreviations

ADPCS	Associate Director for Patient Care Services
AES	All Employee Survey
COS	Chief of Staff
DMS	Daily Management System
ELB	Executive Leadership Board
ELT	Executive Leadership Team
FTE	full-time equivalent
HFMEA	Healthcare Failure Mode and Effect Analysis
HRO	High Reliability Organization
JPSR	Joint Patient Safety Reporting
NCPS	National Center for Patient Safety
OHT	Office of Healthcare Transformation
OIG	Office of Inspector General
QSV	Quality, Safety and Value
RCA	Root Cause Analysis
SAIL	Strategic Analytics for Improvement and Learning
SEC	Senior Executive Council
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

As part of the Office of Inspector General's (OIG) ongoing efforts to enhance its oversight reports, the Office of Healthcare Inspections is exploring different ways to understand and evaluate systems and processes in Veterans Health Administration (VHA) facilities and identify opportunities for improvement.¹² To this end, the OIG conducted a review of select aspects of operations and performance at two VHA facilities in the same Veterans Integrated Service Network (VISN X) that historically ranged from lower performing (Facility A) to higher performing (Facility B).

Although the OIG typically identifies the facilities that are the subject of inspection reports, unless the demands of the Privacy Act counsel against it, this report does not do so. The OIG has previously published inspection reports, including hotline inspections and Comprehensive Healthcare Inspection Program reports, about each of the facilities discussed in this report that do identify the facilities. However, the purpose of this report is not to identify specific failures or challenges faced by either facility. Rather, the intent of this report is to identify and compare characteristics of a relatively high-performing facility against those of a relatively low-performing facility to draw lessons about how lower-performing facilities may improve the quality of medical care. The purpose of affording confidentiality to quality assurance records is to ensure candor and reliability in the process.¹³ The OIG intends for this review to serve as another tool to help VHA and VISN leaders identify strategies for improvement when facilities under their purview experience performance challenges similar to Facility A.

Facility A has been a lower performer for many years as measured through VHA and OIG systems, and allegations of poor care and inadequate staffing have prompted repeated OIG reviews and reports over the past several years. In each instance, the OIG focused on responding to specific allegations and the facility's compliance with established policies, making recommendations to address the deficiencies and conditions identified during the inspection. While this approach complied with the Council of the Inspectors General on Integrity and Efficiency guidelines for inspections and evaluations, Facility A has not been able to fully implement a broader strategy resulting in sustained improvements, as evidenced by its ongoing lower performance in multiple areas. For this reason, the OIG sought to evaluate Facility A's performance from a different perspective. The intent of this report is not to suggest that

¹² VA OIG, [Focused Performance Review of Select Metrics at the Ioannis A. Lougaris VA Medical Center in Reno, Nevada](#), Report No. 19-09486-204, July 30, 2020. This report is an example of OIG's effort to evaluate facilities from a different perspective; the Ioannis A. Lougaris VA Medical Center was not Facility A or B as discussed in this report.

¹³ S. Rep. No. 96-876, at 31 (1980); 38 USC § 5705.

Facility A is failing to provide quality care to the veterans it serves, but rather to identify the underlying and sometimes abstract factors potentially contributing to lower performance. The OIG considers this type of review to be another tool for VHA and VISN leaders to study and consider when facilities under their purview experience similar performance challenges as those experienced by Facility A.

The OIG assessed Facility A with a similar-sized and complexity facility that has been a higher performer (Facility B) as a way to understand and differentiate the underlying conditions, unique characteristics, and general operations and processes that impact a facility's overall performance.¹⁴ Facilities A and B both provide primary, tertiary, and long-term care in multiple clinical areas and specialties, and are classified as Level 1a–High Complexity facilities.¹⁵ As of July 2021, Facility A operated three primary care community-based outpatient clinics (CBOCs), had a total of 396 operating beds, and was affiliated with a university and numerous other academic institutions.¹⁶ As of July 2021, Facility B operated six primary and multispecialty care CBOCs, had a total of 136 hospital operating beds, and was affiliated with major medical colleges and other academic institutions.

Performance Measurement

VHA's Office of Analytics and Performance Integration, part of the Office of Quality and Patient Safety, launched the Strategic Analytics for Improvement and Learning (SAIL) model to help define performance expectations in relation to nine quality domains and one efficiency and capacity domain.¹⁷ This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Although SAIL has noted limitations, the data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.¹⁸ A table of SAIL measures and weights is presented in [appendix A](#).

¹⁴ The OIG acknowledges that many factors influence operations and performance, and that Facilities A and B offer only a relative basis for comparison. Nevertheless, performance expectations for VHA facilities are generally uniform and well defined. It is in this context—the common performance goal—that the OIG considered the facilities' characteristics, processes, and other factors that affect a facility's ability to achieve performance goals. Although some of the factors may be more conceptual than concrete, they could nevertheless provide a basis for process improvement, action planning, or systems redesign initiatives.

¹⁵ VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and Level 3 facilities are the least complex.

¹⁶ Facility A operating beds included spinal cord injury, nursing home care, and blind rehabilitation.

¹⁷ VHA Office of Public Affairs. VHA Program Offices are responsible for the collection, validation, and modeling of data for established quality, efficiency, and access metrics that are used for SAIL model calculations.

¹⁸ VA OIG, [Comprehensive Healthcare Inspection of the Alaska VA Healthcare System, Anchorage, Alaska](#), Report No. 19-00054-72, January 28, 2020 (see pages 13–14). The Alaska VA Healthcare System was not Facility A or B as discussed in this report.

Facility A

An OIG analysis of SAIL performance and other quality data revealed that Facility A was generally a lower performer in comparison to other VHA facilities nationwide from October 1, 2017, through September 30, 2020.¹⁹ An internal OIG risk-stratification model categorized Facility A as either a high risk or on a watch list from January 2019 through September 2020. (See [appendix B](#) for details about the medical facility risk-stratification model used by the OIG.) In calendar years 2019–2020, the Office of Healthcare Inspections published six reports about health care and processes, among other issues, at Facility A, and made a total of 103 recommendations for improvement.²⁰

Facility B

An OIG analysis of SAIL performance and other quality data revealed that Facility B was generally an above-average performer in comparison to other VHA facilities nationwide from October 1, 2017, to December 31, 2018, and became a high performer from January 1, 2019, through September 30, 2020.²¹ The Office of Healthcare Inspections published one routine review during the calendar years 2019–2020, which yielded a report with 13 recommendations.²²

[Appendix C](#) includes budget and workload for both Facilities A and B from October 1, 2017, through September 30, 2020. Of note, leaders at both facilities reported that their respective budgets were satisfactory to meet clinical and administrative needs, largely removing funding as a potential factor explaining performance differences.

VHA’s Journey to High Reliability

High-reliability organizations (HROs) are organizations that have been shown to experience fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments. A basic tenet of HROs is Just Culture, which is a “systems approach to

¹⁹ VA OIG Risk-Stratification Model. Facility A was an average performer from January 1 through March 31, 2018.

²⁰ The OIG acknowledges that when a VHA facility is subject to a succession of reviews resulting in multiple focused recommendations, the facility can often spend time responding to inspection team requests and reacting to the recommendations, which reduces the time and resources available to proactively plan. Further, when a facility misses opportunities to consistently engage in proactive operational planning to ensure activities align with the overall mission, priorities can shift and aspects of performance can deteriorate, resulting in new allegations. As such, a self-perpetuating cycle of underperformance can occur. An operational plan is a highly detailed outline of what a facility will focus on for the near future, usually the upcoming year. The Office of Healthcare Inspections published one additional review for Facility A during calendar year 2021 through August 2021, which yielded a report with three recommendations.

²¹ VA OIG Risk-Stratification Model. Facility B was an average performer from April 1 through June 30, 2018.

²² The Office of Healthcare Inspections published two additional reviews for Facility B during the calendar year 2021 through August 2021, which yielded two reports with eight recommendations to the Facility B Director.

understanding vulnerabilities that could result in harm to patients instead of focusing on individual errors.”²³

While VHA has been at the forefront of many initiatives to prevent harm, it has “lacked a coordinated, enterprise-wide effort.” To this end, in 2018, VHA developed an HRO steering committee, and in February 2019, rolled out a new initiative through its Office of Healthcare Transformation (OHT) outlining definitive steps toward becoming an HRO. “VHA HRO implementation refers to the framework and activities used to implement common practices across VHA.” The five guiding HRO principles toward Zero Harm are described by VHA as

- sensitivity to operations (Focus on Front Line Staff and Care Process). Be mindful of people, processes, and systems that impact care;
- preoccupation with failure (Anticipate Risk-Every Staff Member is a Problem Solver). Have a laser-sharp focus on catching errors before they happen and predicting and eliminating risks before they cause harm;
- reluctance to simplify (Get to the Root Causes). Get to the root causes of problems, rather than settling for simple explanations;
- commitment to resilience (Bounce Back from Mistakes). Bounce back from mistakes, get back on track, and prevent those mistakes from happening again; and
- deference to expertise (Empower and Value Expertise and Diversity). Empower and value expertise and diversity of perspectives and insights; Rely on those with the most knowledge of a situation at hand, regardless of rank, hierarchy, position, or other factors.²⁴

Eighteen VHA facilities, including Facility B, were selected as the “first lead group” (or cohort 1) sites for implementation of high-reliability principles in 2019.²⁵ These facilities received an array of intensive HRO-related training, site-specific assessment and planning, and HRO leader coaching support. The OHT Portfolio Manager told the OIG that in 2020, training and support were initiated by OHT for 54 VHA facilities designated as “cohort 2” sites but that planned site assessments were delayed due to COVID-19.²⁶ OHT also provided all 167 VHA facilities with “train the trainer” instruction, which allowed facilities to conduct their own baseline HRO training for all staff. Reportedly, as of April 2021, OHT had not scheduled the

²³ VHA National Center for Patient Safety, “VHA’s HRO Journey Officially Begins,” accessed December 8, 2020, https://www.patientsafety.va.gov/features/VHA_s_HRO_journey_officially_begins.asp.

²⁴ VHA, *VHA High Reliability Organization (HRO) Reference Guide*, March 31, 2021. Pre-Decisional Deliberative Document – Internal VA Use Only.

²⁵ “VHA’s HRO Journey Officially Begins.”

²⁶ World Health Organization, *WHO Director-General’s Opening Remarks at the Media Briefing on COVID-19, 11 March 2020*, accessed November 4, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. VHA Public Health, *Novel Coronavirus Disease (COVID-19)*, accessed on August 5, 2020, <https://www.publichealth.va.gov/n-coronavirus/index.asp>.

remaining VHA healthcare facilities (cohort 3) for some of the organized training activities, for site assessment, or leadership coaching.

Facility A, a cohort 3 facility, was exposed to the HRO model along with a majority of VHA facilities, with an announcement to staff in August 2019 about the start of the organization's journey to high reliability. Although Facility A had not yet received formal OHT support, Facility A leaders initiated local HRO-related activities. As of September 30, 2020, Facility A leaders, managers, and select staff participated in HRO 101 and 201 training (101 and 77 participants, respectively).²⁷ According to information provided by Facility A staff, baseline HRO training was added to the new employee orientation curriculum, and in January 2021, all Facility A staff were reportedly assigned HRO training modules.²⁸

Facility B started a high-reliability initiative with The Joint Commission and the hospital association in the facility's state in 2013. The multi-year engagement "aimed at moving health care toward the same highly reliable performance seen in industries such as aviation and nuclear power." As a result of this partnership and participating as a VHA HRO pilot site, Facility B leaders and staff have had substantial exposure to the principles. Facility B has had a High Reliability Program Manager since July 2019, and this program manager told the OIG that HRO principles have been incorporated into leaders' executive career field performance appraisals since 2020. As of September 30, 2020, Facility B staff participated in HRO 101 and 201 training (2,706 and 2,713 participants, respectively).

The journey to becoming an HRO occurs over months and years and, by its nature, is never fully completed. Facilities can be accomplished in adopting some HRO principles and challenged in others. VHA's OHT maintains a dashboard of metrics that can be used by facilities and VISNs to prioritize and target their HRO-related activities. Facilities A and B were at different stages in their HRO journeys, which provides yet another context in which to consider performance.²⁹

²⁷ VHA Journey to High Reliability - HRO 101, "This training provides a brief overview of the VHA Journey to High Reliability. This training is the first step to understand the history of HRO, how it will impact employees and Veterans and why it is so important to embark on this culture change now." Continued VHA Journey to High Reliability – HRO 201, "This training provides deeper and more specific information about the VHA Journey to High Reliability, including descriptions of VHA's HRO principles and examples of each in practice." *VHA HRO Reference Guide*.

²⁸ VHA's HRO-related 2020 goals for all facilities focused on training, continuous process improvement, site assessments and planning, leadership coaching, and experiential learning.

²⁹ Jennifer L. Sullivan, Peter E. Rivard, Marlena H. Shin, and Amy K. Rosen, "Applying the High Reliability Health Care Maturity Model to Assess Hospital Performance: A VA Case Study," *The Joint Commission Journal on Quality and Patient Safety*, 2016, accessed January 12, 2021, <https://www.sciencedirect.com/science/article/pii/S1553725016420805?via%3Dihub>.

Scope and Methodology

The OIG initiated this review on June 9, 2020.

The OIG approached this review by identifying and evaluating several key elements and operational areas that can influence a healthcare facility's performance, including leadership stability and succession planning; and the Quality, Safety and Value (QSV) program, including the patient safety program and practices and committee reporting structure and practices. The OIG also reviewed facility culture, including communication and engagement, problem identification and resolution processes (with a focus on COVID-19 response and management of academic affiliations), and resilience and innovation; and human resource management and staffing in key clinical areas.³⁰ When applicable, the OIG considered the review elements and operational areas in the context of the HRO framework. The OIG also evaluated facility processes in three quality domain measures—adverse patient outcomes, inpatient and outpatient performance measures, and employee satisfaction.

The review period covered select Facility A and B operations from October 1, 2017, through December 31, 2020, with additional information requested in February and March 2021 for clarification. The OIG team reviewed documents including VHA handbooks and directives; facility policies, standard operating procedures, and memorandums; organizational charts and staffing data; committee charters, agendas, and meeting minutes; quality reviews, patient safety reports, external reviews, and All Employee Survey (AES) results; and VHA SAIL and internal OIG risk-stratification data for VHA facilities.

While data and documentation provide pertinent information, often from a big picture vantage point, experiences and conditions *on the ground* can provide context that better explains the data. The goal of this review was to identify the underlying and sometimes abstract factors potentially contributing to lower performance; therefore, the OIG gave considerable weight to the opinions and perspectives of leaders and staff when determining the advantages and challenges at the respective facilities.

The OIG team remotely interviewed the Facility A and B Directors, Associate Directors, Chiefs of Staff (COS), and Associate Directors for Patient Care Services (ADPCS); the Chief or Acting Chiefs of QSV or quality management, mental health, specialty care, medical service, and human resource management; patient safety managers; and inpatient unit nurse managers; SAIL and AES coordinators; and other staff who had knowledge related to the areas of interest.³¹ In

³⁰ QSV and quality management are used interchangeably throughout the report and the Chiefs of QSV and quality management are the same position in the two facilities.

³¹ At Facility A, an initial acting ADPCS and then a secondary acting ADPCS had been in those roles since July 2019 and July 2020, respectively. An acting Chief of Quality Management had been in that role since September 2020.

addition, the OIG team interviewed the VISN Quality Management Officer and Human Resource Officer, as well as VHA's OHT Portfolio Manager.

In the absence of current VA or VHA policy, the OIG will consider previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 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 inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

As previously noted, the OIG selected for review two VHA facilities in the same VISN (VISN X) that historically ranged from lower performing (Facility A) to higher performing (Facility B). After completion of extensive interviews and process reviews, the OIG determined that the facilities approached and addressed most issues similarly. However, the efficiency and effectiveness of actions and processes in some areas varied from Facility A to Facility B.

In the body of this report, the OIG discusses two broad factors that directly shaped each facility's ability to focus, prioritize, and accomplish progressively higher performance. These areas lent themselves to possible proactive VISN or VHA central office-level interventions and mitigation strategies, and included

- leadership, including stability, unity, and succession planning, which is foundational and provides a level of constancy and consistency necessary to promote trust, productivity, and innovation; and
- QSV Program and HRO Integration, which provides the organizational infrastructure that supports and formalizes quality, safety, and oversight expectations and activities.

The OIG also determined that facility culture and human resource-related considerations affected operations and performance. Facility culture is defined as "a set of behaviors, beliefs, policies, and actions that are regularly implemented within a particular setting" and, in the context of this report, includes communication and staff engagement, problem identification and resolution

processes, and resilience and innovation.³² Human resource management refers to each organization's ability to ensure adequate recruitment and retention of qualified staff to meet the organization's mission. The areas reviewed for this report generally included the impact of VHA's Human Resources Modernization on Facility A and B's abilities to support recruitment and hiring activities; recruitment and retention incentives to reduce hiring challenges in the local employment market; and strategies to minimize registered nurse turnover.³³ The OIG did not identify distinct opportunities in the areas of facility culture and human resource management for VISN or VHA central office-level interventions beyond those already occurring through HRO implementation, Human Resources Modernization, or other operational processes. However, exploration of the underlying themes may reveal additional opportunities for improvement.

1. Leadership

Over the years, chronically high turnover in Facility A's executive leadership team (ELT) resulted in a lack of cohesion and inconsistent direction that affected facility performance. Further, ongoing vacancies in several ELT positions potentially jeopardize Facility A's ability to demonstrate a united and consistent HRO "message" across the organization.

Good leadership is central to the health and success of any organization. According to The Joint Commission, leaders establish the organization's culture through their words, expectations, and behavior. Further, The Joint Commission specifically discusses the importance of the leadership team having a shared understanding of what they want to achieve and why, and how they want to achieve it. Specifically, "The greater the alignment among the leadership groups with respect to the hospital's mission, vision, and goals, the more likely they can effectively function as a team to achieve those goals."³⁴ Effective hospital performance depends on how well leaders work together, integrate different skills, and consider varied leadership perspectives.³⁵ In the context of cultural transformation to becoming an HRO, leaders "set the bar" for values and behavior.³⁶

³² Standards of Care, *Healthcare Culture*, "a set of behaviors, beliefs, policies, and actions that are regularly implemented within a particular setting," accessed February 17, 2021, <https://www.standardsofcare.org/healthcare/culture/>.

³³ Turnover is the number of staff who have left the organization, typically given as a percentage in the last 12 months. VHA Research Series: *The Business Case for Work Force Stability 2002*, accessed August 20, 2020, <https://www.leg.state.nv.us/Session/72nd2003/Interim/StatCom/HealthCareDelivery/exhibits/11617K.pdf>.

³⁴ A Governance Institute White Paper, "Leadership in Healthcare Organizations. A Guide to Joint Commission Leadership Standards," Winter 2009, accessed February 18, 2020, https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/wp_leadership_standardspdf.pdf?db=web&hash=86F0223A5C016F833DA3DDB1C62F5D20.

³⁵ The Joint Commission, *Standards Manual E-dition*, LD.01.01.01, July 1, 2020.

³⁶ The Joint Commission, *High Reliability Transformation Requires Leadership to Embrace Improvement*, June 19, 2018.

Stability and Unity

The ELTs at both facilities followed a Pentad model, which consists of a Facility Director, COS, Assistant Director, Associate Director, and ADPCS. While not an ELT position, the OIG has included the QSV chief in this section given the critical nature of this position in hospital operations and performance. Figures 1 and 2 reflect the approximate tenures of, and changes to, ELT members and the chiefs of QSV at Facilities A and B from January 2017 through December 2020. The figures are intended to show those times when temporary assignments within the ELT and with the QSV chief could have slowed actions or innovations that might have progressed under permanent team members working toward a collective goal. For the purpose of this review, the OIG considered a vacated position covered by a detailed employee, or a series of detailed employees, for greater than three months to meet this criterion.³⁷ Permanent assignments are shown as a solid bar, whereas temporary assignments greater than three months are shown as a cross-pattern bar.³⁸

Facility A

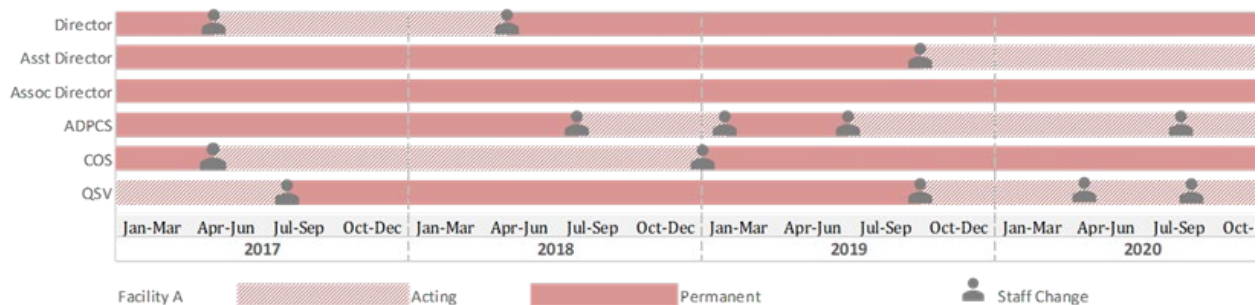


Figure 1. Facility A Leadership Tenure January 2017–December 2020.
 Source: OIG analysis of Facility A interviews and Human Resources documentation.

Over the years, Facility A has experienced ongoing turnover of the leadership team, with the current Facility Director of four years (one year in an “acting” capacity and three years in a permanent position) reportedly being the longest serving director in 15 years. A leader estimated there had been 10 acting or permanent facility directors in the past 10 years, and another leader estimated there had been “at least” 70 ELT members in the past 10 years. In addition, the OIG learned that on three occasions since 2018, ELT members were detailed to other positions pending the outcomes of internal investigations (all of which lasted greater than six months). As would be expected, these unoccupied positions were filled by employees detailed during that

³⁷ The OIG considered Facility A’s Assistant Director and ADPCS positions to be unoccupied during the period the incumbents were being investigated as it was uncertain if and when they would return to those ELT positions.

³⁸ Preceding the OIG’s review, the Facility B permanent Director was detailed to acting VISN Director for more than three months, during which time Facility B’s Associate and Assistant Directors performed the Director’s duties. They resumed their regular positions when the Facility B Director returned from the VISN detail.

time; however, lengthy details could further destabilize the ELT. Turnover has multiple causes and “may affect...the capacity of the agency to...fulfill long-term commitments.”³⁹

The OIG identified a byproduct of Facility A’s leadership turnover during a review in November and December 2018 to assess a series of administrative and clinical concerns. At the time, the Assistant and Associate Directors had been stable in those roles; but, the remainder of the ELT and the QSV chief were either fairly new or were temporary in their roles. The OIG report outlined several challenges at Facility A, including leaders’ communication styles and responses, which were not consistently viewed by staff as professional, positive, or oriented toward problem solving.⁴⁰

During OIG interviews in August and September 2020, Facility A leaders reported that although the leadership team was still in transition, they had good “synergy” and communication that they did not have in the past.⁴¹ They also generally expressed optimism about the composition and increasing stability of the team. The Facility A Director told the OIG that securing permanent leaders was still an area of “opportunity” but reported being “hopeful” that a stable leadership team will continue to move the facility in the right direction.

The OIG noted that the Facility A Director held multiple leadership positions at VHA facilities and at the VISN level since 2010, which included a 2017 detail to Facility A in the acting director role, a position that became permanent about one year later. As previously discussed, Facility A was a high-complexity facility with high leadership turnover and ongoing lower performance, and was also challenged by low employee satisfaction. The OIG was informed that in 2018, conflict existed within the facility’s ELT and management ranks. At the time, oversight was coming from a VISN that was mired in personnel-related issues and reacting to adverse events and negative publicity at several of its other facilities. While the Facility A Director reported having two mentors, those mentors were not assigned until 2019, and did not visit Facility A until late January and early March 2020, respectively.

³⁹ James C. Clinger, “Turnover at the Top: Causes and Consequences of Leadership Change in Public Agencies,” *Global Encyclopedia of Public Administration, Public Policy, and Governance*, January 2016, accessed December 23, 2020, https://www.researchgate.net/publication/309304899_Turnover_at_the_Top_Causes_and_Consequences_of_Leadership_Change_in_Public_Agencies.

⁴⁰ In August 2018, the ELT participated in a National Center for Organizational Development survey evaluating the group’s strengths and challenges. The National Center for Organizational Development results showed that dialogue was not “particularly natural for this group” and that the group seemed “more inclined to use a challenging approach than a receptive one.”

⁴¹ Merriam-Webster, “Synergy,” accessed April 21, 2021, <https://www.merriam-webster.com/dictionary/synergy>. Synergy is “a mutually advantageous conjunction or compatibility of distinct business participants or elements (such as resources or efforts).”

Facility B

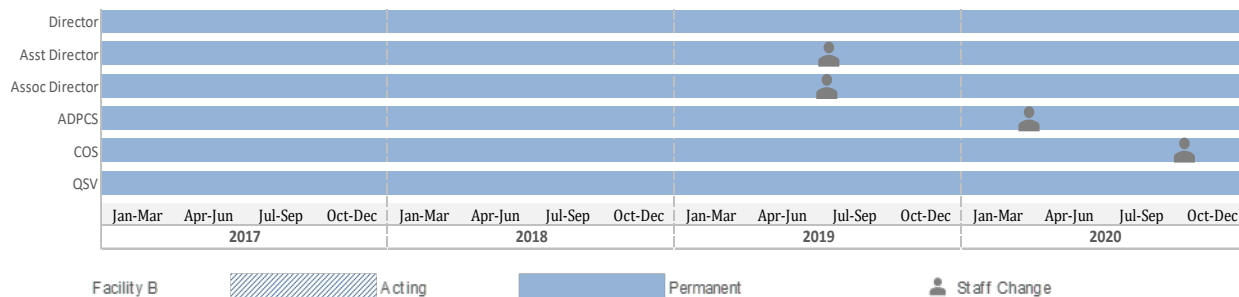


Figure 2. Facility B Leadership Tenure January 2017–December 2020.

Source: OIG analysis of Facility B interviews and Human Resources documentation.

Facility B has been a solid or higher performing VHA facility for many years. The previous director of Facility B (2010–2013) was named VHA’s mentor of the year in 2012, and the current Facility B Director told the OIG of inheriting a very stable leadership team. During an interview, the OIG was informed that despite several recent changes to the ELT, the long and successful tenures of the Facility Director and previous COS at Facility B contributed to a stable environment that was foundational to consistent direction and set the stage for high performance over time. Facility B’s previous COS reported that executive leaders had joint ownership of everything that happened in the facility and a Facility B service chief confirmed to the OIG that the executive leadership helped “make it happen” when there were barriers.

Succession Planning

VA Directive 5002, *Department of Veterans Affairs (VA) Workforce and Succession Planning*, January 15, 2003, describes workforce and succession planning as “the continuous management process of determining the kinds of employees and infrastructure required to accomplish VA’s mission and the development and implementation of strategies to meet those needs.” It further establishes requirements and responsibilities for succession planning across VA.⁴² Succession planning is vital to ensuring there are highly qualified people in key positions “today and in the future,” and provides operational stability and consistency in a highly complex, high-risk field.

⁴² VA Directive 5002, *Department of Veterans Affairs (VA) Workforce and Succession Planning*, January 15, 2003. GAO-20-15, *Improved Succession Planning Would Help Address Long-Standing Workforce Problems*, October 10, 2019. This report noted that VA had not produced a Department-wide succession plan since 2009, nor had it updated its succession planning directive since 2003. Further, the 2003 directive does not incorporate legal requirements put in place since then. GAO recommendations to VA generally revolved around the need for better planning “to develop the next generation of leaders and fill key positions.” As of January 2021, VA’s efforts to develop a Department-wide succession plan, with associated guidance and metrics, were ongoing with expected completion dates for the various components in 2021.

Facility A

Although Facility A leaders repeatedly identified the need for permanency in leadership positions, none of the ELT members suggested that succession planning was a possible means to achieve this goal. The OIG determined that ELT turnover and accountability issues at the service line manager and supervisory levels may, in part, be reasons that succession planning had not been a historic or routine practice at Facility A. The OIG found that the lack of targeted succession planning was a factor contributing to the series of temporarily assigned employees in key roles and perpetuated Facility A's leadership instability and its attendant problems.

Facility B

The minimal use of temporarily assigned employees at Facility B's ELT level, as well as the QSV chief's level, provides compelling evidence of effective succession planning practices. Specifically, several leaders identified in Figure 2 were "home grown," occupying deputy-level positions immediately preceding elevation to their current positions. Also, the previous incumbents were stable in their roles, serving 4–20 years, and several ELT members commented about the strength of the service chiefs, who supported seamless operations when there was leadership turnover such as the long-term COS's retirement in 2020. In August 2020, the Facility B Director told the OIG that 75 percent of service chiefs could retire at that moment or within five years, making succession planning an opportunity and priority.

Why it matters: The ongoing turnover in Facility A leadership over the years has hampered leaders' ability to consistently focus on team and trust building, as well as succession planning for key positions. These are central components to maintaining stability and enhancing organizational performance. Facility A leaders and others the OIG interviewed expressed enthusiasm about the stability and direction of the current ELT; however, the years-long process leading to this point has been marked by low employee satisfaction and ongoing lower performance in relation to multiple quality domains. Given the known and long-standing challenges and other circumstances surrounding Facility A, the OIG believes that VISN X had an opportunity to provide targeted support and resources earlier in the Director's tenure. The OIG could not say whether earlier assistive measures would have substantially changed Facility A's course since 2017. However, these measures may have provided Facility A's Director and other ELT members with a more focused path forward and strengthened leaders' ability to proactively manage some of the pitfalls common to transitioning teams.

2. QSV Program and HRO Integration

High turnover in the QSV chief position at Facility A has contributed to deficits in the QSV program. This condition, coupled with deficient committee reporting and follow-up processes, may hamper Facility A's ability to consistently align around the HRO framework to achieve Zero Harm.

QSV programs across VHA are responsible for multiple functional areas, including quality management, patient safety, business compliance, and systems redesign. Although VHA's QSV-related guidance has evolved over the years and employed different approaches to support continuous quality improvement, VHA has consistently required facility-wide integration of key QSV functions.⁴³ In October 2019, VHA rescinded Directive 1026, *Enterprise Framework for Quality, Safety, and Value*, and in December 2019, issued VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*.⁴⁴ The purpose of VHA's rescission of the directive was to remove conflicts with VHA's "modernization efforts," which are "part of the new VHA governance process," and include a plan to develop "new guidelines and a national directive to support a coordinated organizational quality and safety program to align with current lanes of efforts, high reliability and modernization." The OIG was told that as of April 27, 2021, a new Quality and Patient Safety directive has been drafted and undergoing review with a plan to publish by the end of September 2021. Directive 1026.01 states that systems redesign and improvement activities should be incorporated "into the QSV strategic planning processes, VHA enterprise quality framework, and HRO framework."⁴⁵ The path to achieving Zero Harm in a high-risk environment relies on the strength and interconnectedness of QSV and patient safety processes, HRO integration, and reporting and oversight.

The QSV chief position at Facility A has been in flux over the years, and although there was one permanent QSV chief for slightly more than two years (2017–2019), this relative stability did not serve to appreciably strengthen the QSV program. Starting in October 2019, Facility A has had a series of acting QSV chiefs, all during a time when VHA has been increasingly emphasizing HRO integration and alignment within the organizational structure. In March 2020, the QSV organizational chart for Facility A included 24 full-time equivalent (FTE) employees with largely traditional roles including risk management, accreditation, and credentialing and privileging. An approved organizational chart for the newly integrated Office of High Reliability/Quality, Safety and Value, on January 6, 2021, greatly expanded staffing to 48 FTE, and included new roles such as an associate director for HRO and QSV; chief of quality operations; additional patient safety and clinical risk managers; section chiefs for patient safety, risk management, and quality analytics; and additional quality consultants, auditors, and

⁴³ VHA Directive 2009-043, *Quality Management System*, September 11, 2009, was rescinded and replaced by VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. The 2009 and 2013 directives have the same or similar language regarding facility-wide integration of key QSV functions.

⁴⁴ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013, was rescinded by VHA Notice 2019-21, Rescission of VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, October 24, 2019. The 2013 directive was replaced by VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

⁴⁵ VHA Directive 1026.01. This directive also requires facilities to track, trend, and report specified data to the respective VISN governance committees. The VISN Quality Management Officer told the OIG that facilities were reporting via the VISN template, as required. Each facility's report is reviewed at the VISN Executive Leadership Committee when that facility is due to present.

investigators.⁴⁶ As of April 21, 2021, three of the new positions had been filled and six were in the hiring process. The remaining positions were awaiting completion of a functional statement or position description.

Facility B's Chief of Quality Management has been stable in that role since 2015. As of February 2021, Facility B's pending QSV organizational chart, covering traditional QSV-related roles, included 15 FTE.

To assess each facility's QSV program, the OIG team reviewed several processes and data points that provide insight into a program's strength and oversight, including

- selected patient safety activities, including event reporting and analysis, Healthcare Failure Mode and Effect Analysis (HFMEA), and Root Cause Analysis (RCA), as well as peer review and credentialing and privileging; and
- integration of the HRO framework as evidenced by the facility-level governance and committee structure, as well as compliance with VHA guidance for committee documentation, reporting, and follow-up.

Patient Safety Activities

VHA's patient safety program is designed to prevent patient harm related to the medical care provided in VHA facilities and embodies the HRO principles of Sensitivity to Operations and Preoccupation with Failure.⁴⁷ High reliability depends on staff at all levels constantly assessing for system weaknesses and improvement opportunities, and staff members must have a sense that their work culture is just and that they can safely report identified errors, near misses, and adverse events without fear of retribution.⁴⁸ Leaders in HROs are responsible for creating conditions where employees feel safe reporting actual and potential safety events.⁴⁹

Patient Safety Event Reporting

VHA policy requires staff to report patient safety events of which they are aware to the patient safety manager even if the condition has not resulted in an adverse event, close call, or adverse

⁴⁶ Credentialing and privileging staff at both facilities were realigned from QSV to the COS office starting in October 2020.

⁴⁷ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

⁴⁸ Jennifer L. Sullivan, Peter E. Rivard, Marlina H. Shin, and Amy K. Rosen, "Applying the High Reliability Health Care Maturity Model to Assess Hospital Performance: A VA Case Study." *The Joint Commission Journal on Quality and Patient Safety*, Volume 42, no. 9 (September 2016): 389–399.

⁴⁹ American College of Healthcare Executives, *Leading a Culture of Safety: A Blueprint for Success*©, 2017, pages 1–41.

clinical outcome.⁵⁰ VHA captures errors, close calls, and near misses utilizing the Joint Patient Safety Reporting (JPSR) System.⁵¹ After receipt of reported patient safety events, the patient safety manager reviews the event and assigns a safety assessment score to determine the need for further review.⁵² The patient safety manager should track patient safety-related event data, which may identify opportunities for systems-level evaluations and improvements.

Based on document reviews or interviews, the OIG determined that both facilities utilized the JPSR System to report and document actions taken in response to patient safety events and that information was recorded in WebSPOT for those events resulting in an RCA, new employees were trained on patient safety and JPSR during new employee orientation, and patient safety staff routinely interacted with nurse managers and other staff.⁵³ However, the OIG noted some differences in JPSR reporting at each facility as set forth below.

Facility A

Facility A's patient safety program policy states that "identification and reporting of patient safety events, including those that result from practitioner error, are critical to...efforts to continuously improve patient safety. Likewise, medical managers have a duty to recognize the inevitability of human error and attempt to design systems that make such error less likely; and to avoid punitive reactions to honest errors."⁵⁴ The policy also outlines the broad expectation of "if in doubt, report," and improves access to reporting methods by requiring a JPSR shortcut icon on every computer in the facility as well as a link to the JPSR on Facility A's intranet page.

A Facility A leader told the OIG that the facility was moving toward having a Just Culture supporting HRO initiatives, but that Just Culture practices had not permeated the facility.⁵⁵ As an example, Facility A's Patient Safety Annual Reports (FY 2018–FY 2020) reflected a decrease in

⁵⁰ VHA Handbook 1050.01. Adverse events are "...untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility." "A close call is an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention." Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher-level care.

⁵¹ VHA National Center for Patient Safety, *JPSR Business Rules and Guidebook*, July 2020. JPSR is a user-based web application for frontline VHA users to report patient safety events.

⁵² VHA Handbook 1050.01 states that severity assessment scores are determined based on the severity category (events can be catastrophic, major, moderate, or minor) and the probability category (events can be frequent, occasional, uncommon, or remote), and define when a further patient safety review is required.

⁵³ VHA Handbook 1050.01; WebSPOT (not an acronym) is a VHA information system hosted by the National Center for Patient Safety and is used to capture root cause analyses and other aggregated reviews.

⁵⁴ Facility A Policy 3400, *Patient Safety Program*, January 2019.

⁵⁵ The Facility A Director told the OIG that when starting in the role, part of the facility's culture could be characterized by mistrust and fear, citing the case of an employee who went to prison for falsifying consults, as well as the cases of several executive- and service-level leaders being removed for various offenses. The Facility A Director commented that these events impacted "the sense of psychological safety that the organization has."

the number of reported events since 2018. The Patient Safety Annual Reports contained summaries and trending for relevant matters such as falls, medication events, and hospital acquired pressure ulcers, and also included lessons learned and patient safety improvement activities. While Facility A included the required information in reviews of JPSR-reported events, analysis and action planning tended to lack detail regarding circumstances surrounding the event, as well as mitigation efforts and actions taken to avoid future events.

Facility B

Facility B's patient safety program policy states that the overall goal of the program is to "improve the quality of patient care by promoting a proactive and just safety culture and by designing or redesigning patient care systems as needed."⁵⁶ The policy further states, "Just Culture is an organizational safety culture fostering prevention of harm and psychological safety by encouraging employees to speak up about safety events or concerns without any fear of punishment or other negative response for reporting."

During interviews, the OIG did not hear concerns about Just Culture or psychological safety at Facility B. The OIG was told about an interactive environment where patient safety staff communicate directly with staff who submit patient safety event reports through JPSR, seeking clarification when needed, or providing feedback about actions taken, when appropriate.

According to Facility B's Patient Safety Annual Reports (FY 2018–FY 2020), the number of patient safety event reports increased by about 44 percent since 2018. An increase in safety-related event reporting is a positive development as it often reflects the staff's understanding of what to report and how to report it, as well as staff having a reasonable sense of psychological safety when reporting potentially unfavorable information. The Patient Safety Annual Reports contained summaries and trending for relevant matters such as falls, medication administration-related issues, HRO training, and a breakdown of issues associated with communication.

Overall, the OIG found that Facility B's reviews consistently included details about reported events, contributing factors, lessons learned, and actions taken. Detailed review and critical analysis of patient safety events, near misses, and other reported deviations from the expected result are hallmarks of high reliability.

HFMEAs and RCAs

VHA facilities also evaluate why problems exist through HFMEA and RCA processes.

VHA policy requires completion of a proactive risk assessment using the HFMEA model every 12 months.⁵⁷ The proactive risk assessment is a process to identify and evaluate systems

⁵⁶ Facility B Policy 00QM-18-03, *Patient Safety Program*, January 2018.

⁵⁷ VHA Handbook 1050 01.

vulnerabilities, to include the associated corrective actions, prior to adverse events occurring. Facilities A and B conducted the required HFMEAs. The OIG noted, however, that Facility A's policy required an HFMEA every 18 months rather than every 12 months, which is inconsistent with VHA policy.⁵⁸

VHA policy requires facilities to complete a minimum of eight RCAs and aggregate reviews annually to encourage facilities to identify and mitigate vulnerabilities in their systems of care.⁵⁹ The National Center for Patient Safety (NCPS) describes the goal of the RCA process as a way to find out what happened, why it happened, and how to prevent it from happening again, with a focus on prevention rather than punishment. Based on specified criteria, NCPS recognizes high levels of performance regarding RCAs and aggregated reviews to include Bronze, Silver, and Gold Cornerstone Recognition. Both facilities were recognized by NCPS and received the Gold Cornerstone Recognition in fiscal years 2018 and 2019.

In relation to peer review and credentialing and privileging, the OIG determined that overall, Facilities A and B both had solid processes and tracking systems to identify and address provider-related practice deficits and credentialing and privileging discrepancies.

HRO Integration and Committee Reporting and Follow-Up

VHA and facilities' policies require integration across the organizational structure to promote the exchange and flow of quality-related data and avoid organizational silos.⁶⁰ This organizational integration is addressed, in part, through a formal committee reporting structure headed by an executive leadership body.⁶¹ Facility A's Executive Leadership Board (ELB) and Facility B's Senior Executive Council (SEC) provide oversight of subordinate council, committee, and board activities, including final review and approval of recommendations or actions.

Measuring the impact and effectiveness of HRO integration into a facility's governance and culture can be challenging. The OIG evaluated a variety of objective operational and organizational data to understand how each facility was complying with basic committee structures, reporting requirements, documentation, and follow-up activities when patient safety

⁵⁸ VHA Handbook 1050.01; Facility A Policy 3400.

⁵⁹ VHA Handbook 1050 01.

⁶⁰ VHA Directive 2009-043, *Quality Management System*, September 11, 2009. VHA Directive 1026, *VHA Enterprise Framework for Quality Safety and Value*, August 2, 2013. VHA Directive 2009-043 was rescinded and replaced by VHA Directive 1026. VHA Notice 2019-21 rescinded VHA Directive 1026 on October 24, 2019. After VHA rescission of national policy, facilities relied on local policies for quality management. The local policies included Facility A Memorandum No. 0006, *Medical Center Governance*, August 9, 2019, and Facility B Policy 00QM-17-01, *Quality Management Program*, August 3, 2017, rescinded by Facility B Policy 00-QM-20-01, *Quality Management Program*, February 2021. Facility B Memorandum Number 00-QM-19-13, *Committee Structure*, July 23, 2019.

⁶¹ VHA Directive 1026; Facility A Memorandum No. 0006; Facility B Policy 00QM-17-01; Facility B Policy 00-QM-20-01; Facility B Memorandum Number 00-QM-19-13.

issues were brought forward. Meeting minutes are the communication tools to ensure critical information is provided to the executive leadership body and to subordinate councils, committees, and boards. Each facility's policy requires meeting minutes to track issues "to completion."⁶² The OIG evaluated selected council, committee, and board meeting minutes from the respective facilities for October 1, 2019, through February 22, 2021, to determine whether reporting processes were sufficient to support the high-reliability goal of No Harm.⁶³

Facility A

The OIG identified opportunities for Facility A to enhance communication and the flow of information by improving the quality and content of meeting minutes.

The ELB minutes did not consistently document an adequate description, analysis, or discussion of the issues, or document action items and follow-through reflecting action completion. At times, the ELB meeting minute discussion section included "information only," or was left blank; the status section was marked as "closed;" and some minutes included embedded documents rather than an analysis or documented discussion of information. For example, the OIG found a reference to a concern about view alerts; but, the description of the concern did not clarify the extent of the problem or a clear action plan to address it.⁶⁴ In another example, while Facility A's peer review and credentialing and privileging processes for identifying and addressing issues were appropriate, meeting minutes did not consistently provide the level of detail needed to understand the significance of some issues, such as an overdue provider evaluation, and what action, if any, was needed.

The Facility A Director stated during an OIG interview that "we target our performance measures, we put processes in place" and "have really worked on building up our system redesign program." Further, the acting QSV chief told the OIG of a bidirectional communication process with quality management-related information reported through the facility council and board structure with communication back to subordinate committees. However, the OIG did not find documented evidence in the ELB meeting minutes that supported these assertions. The OIG determined that inadequate documentation and follow-through in meeting minutes, which are used as tools for communication, could result in quality or safety issues being lost to follow-up.

The OIG also determined that efforts to align Facility A's governance structure around systems redesign and the HRO framework has, while progressing, been slow to take shape. The acting

⁶² VHA Directive 1026; Facility A Memorandum No. 0006; Facility B Policy 00QM-17-01; Facility B Policy 00-QM-20-01; Facility B Memorandum Number 00-QM-19-13.

⁶³ VHA does not require, and neither facility had, a separate Patient Safety Committee; therefore, no minutes were reviewed for patient safety. The review of meeting minutes included Facility A's ELB, Executive Council of Medical Staff, Health Care Delivery Council, and Protected Peer Review Committee; and Facility B's Senior Executive Council, Clinical Executive Board, and Peer Review Committee.

⁶⁴ VistA Computerized Patient Record System (CPRS) Setup Guide, October 2019. Alerts provide notification of pending activities, such as review of a patient's clinical test results.

QSV chief told the OIG that the facility's alignment efforts would be evident in meeting minutes. However, the OIG's evaluation of ELB minutes did not provide strong support for this statement. Specifically, reports submitted by the QSV and Initiative Council for October 24, 2019, to November 30, 2020, continued to present the same standard topics, in the same format, without mention of systems redesign or HRO activities.

Facility B

The OIG found Facility B's meeting minutes reflected topics that were current and relevant based on ongoing national issues (such as the COVID-19 pandemic), discussions that were detailed, and action items that were tracked to completion. HRO principles were integrated into operations and reporting, and HRO activities were documented and discussed at the SEC level.

The Facility B Director told the OIG that HRO principles were used to identify improvement opportunities, which was supported by the SEC minutes that included discussions about the facility's approach to a systems redesign transition and addressed various HRO principles. Overall, the minutes reflected leadership and organizational transparency and a standardized approach of the SEC and subordinate committees to address issues identified by frontline staff and through the various reporting mechanisms. The Chief of Quality Management, who is a member of Facility B's High Reliability Council, stated during an OIG interview that the committee structure was reorganized over the prior two years to align with HRO principles and reported that an HRO Council is in place which is intended to "infuse" HRO principles into "everyday practice."

Why it matters: VHA policy has historically set the framework for integration and coordination of QSV activities. When VHA rescinded previous policy 1026 in October 2019 to support the "new VHA governance process," the rescission memo stated that new guidelines and a national directive to support quality and safety programs would be developed; however, as of May 2021, that had not occurred. The issuance of national guidelines could clarify expectations about how and where some traditional QSV functions fit into the overall organizational and governance structure.

The QSV program in VHA facilities is a cornerstone of hospital operations—when a QSV program is robust, that facility is positioned to perform well in relation to quality of care and patient safety. Conversely, weaknesses in a QSV program are often associated with underperformance or outright failures in quality of care and patient safety. Therefore, the strength of QSV leadership and the adequacy of staffing for key quality and patient safety functions are critical.

VHA has not prescribed a baseline level of staffing to support various QSV program areas; rather, facilities make their own staffing determinations. Facility A's organizational chart included approximately 30 more positions than Facility B's to support similar quality- or safety-related responsibilities. While some of Facility A's new positions appeared to be specific to a

newly integrated Office of High Reliability/Quality, Safety and Value, and thus were tasked with developing processes supportive of HRO integration, Facility B's processes and HRO integration were further developed and therefore did not require the same level of staffing support as Facility A to accomplish the tasks. Nevertheless, the dramatic difference in QSV at the two facilities raises the possibility that redundancies and other inefficiencies may exist in Facility A's QSV staffing model. The VISN X Quality Management Officer was unaware of Facility A's new (January 2021) QSV organizational chart and could not comment on why some QSV programs with substantially fewer staff were successful. VISN Quality Management Officers are responsible for overseeing the VISN's overall quality management program to assure consistency with system-wide goals and strategic objectives. Therefore, VISN Quality Management Officers should be knowledgeable about QSV operations at their respective VISNs.

The OIG recognizes that meeting minute documentation and committee structure are not pillars of an HRO; however, they can give insight into a facility's progress toward a patient-centric cultural redesign. Committee reporting is the primary mechanism to ensure the flow of quality- and safety-related information across the organizational structure, and meeting minutes are the primary tool to document issues and decision-making. Facility A's committee reporting processes did not adequately ensure appropriate situational awareness among facility leaders and staff and often lacked a level of detail necessary to fully understand the issues, and to plan and follow through accordingly. Deficits in Facility A's committee reporting processes may, in part, be an artifact of turnover in the QSV chief position resulting in insufficient guidance and oversight, as well as an underlying acceptance that past (inadequate) practices were satisfactory to meet the goals.

Overall, Facility A has struggled over the years in multiple QSV-related areas. Given the criticality of QSV operations in quality of care, patient safety, and HRO integration, the OIG believes that opportunities exist for VHA central office to provide support to Facility A's QSV department as it works toward increasing its efficiency and effectiveness.

3. Facility Culture

Facility culture is the "set of behaviors, beliefs, policies, and actions that are regularly implemented within a particular setting," and the collective elements of facility culture affect efficiency and timeliness of how the day-to-day work gets done. This section of the report discusses leaders' and managers' perceptions of the overall culture at their respective facilities, as well as how leaders reportedly approached key characteristics of organizational culture—Communication and Staff Engagement, Problem Identification and Resolution Processes, and Resilience and Innovation.

Overall Perception of Facility Culture

Facility A

In OIG discussions with Facility A leaders in the past several years, there was a general consensus that the facility has been plagued by pockets of employees who were resistant (to change) and negative (in their interactions). According to several leaders, Facility A had a history of nonaccountability in certain areas, and when accountability measures were instituted, some affected employees responded with anger and pushback. Facility A has two unions on-site, and while leaders reported that the relationships were generally good with local union leaders, one of the national union leaders had presented challenges on occasion. Productive union relationships are a key component of effective workforce management.

Facility A's COS told the OIG that leadership turnover had shaped facility culture, noting that "when you [do not] have a clear direction...the culture is going to fill that gap." The Associate Director, who was the longest-serving member of the ELT said, "If we could just change the perspective...a little bit, and the culture just a little bit, then great things can happen."

Facility A's AES Best Places to Work data for 2017–2020 reflected performance consistently below the VHA-wide average, and although 2019 results did reflect an improvement of almost 6 percent from the previous year, the 2020 score was in VHA's bottom 10 percent. Employee satisfaction is an indicator of facility culture.

Despite the 2020 AES results, several leaders asserted that the culture was improving, stating, "It looks like a different place," the "culture is much healthier," and there has been a "gross difference in the last 18 months."

Facility B

The culture at Facility B was generally described by leaders and managers as one of high expectations and accountability, with "a vast majority" of staff committed to the mission to provide the best patient care possible. One interviewee noted the ease of holding people accountable in an organization with high expectations. The facility's direction and priorities have been consistent because of stable leadership. Leaders described strong and proactive relationships with the two local unions. Facility B's AES Best Places to Work data for 2017–2020 reflected scores that were generally consistent with the VHA-wide average.

Communication and Staff Engagement

Communication is pivotal to workforce engagement. An analysis about communication competency in health care, published in 2017 on the Patient Safety and Quality Healthcare website, reflected "Strong communication among healthcare team members has been shown to influence the quality of working relationships and job satisfaction, and clear communication about task division and responsibilities has been linked to reduced workforce turnover...." Most

importantly, robust communication significantly contributes to positive patient outcomes in healthcare organizations.⁶⁵ Staff members and leaders across both Facilities A and B told the OIG they viewed communication as an ongoing opportunity at their respective facilities.

Facility A

Facility A leaders and staff members generally told the OIG of long-standing communication challenges and reported that improving communication had been a priority and a goal. Facility A reported communication-related activities that included Director's Town Hall meetings, email updates, Lunch with the Director, huddles, open door policies, and suggestion boxes, among others. Higher-level communication processes, implemented more recently, included implementation of the Daily Management System, ELT lunches, ELT meetings with service chiefs with required follow-up of low-performing measures, and a revised governance structure.⁶⁶ Further, in 2020, and at the suggestion of the Director's mentor, Facility A created an internal communication specialist position with the incumbent responsible for, among other things, information flow and management of assignments between offices.

Facility B

With the exception of the communication specialist position, Facility B leaders and staff members reported communication processes and activities similar to those outlined by Facility A. Facility B's Director told the OIG of posting all the facility meeting minutes, that included resource decisions, on an internal website that was available for all staff. Facility B leaders generally referred to communication and staff engagement as a way to care for veterans, improve the organization, and enhance the workplace, reporting that they sought the opinions and ideas of the frontline staff.

Overall, Facility B staff described communication practices and a follow-up loop that, collectively, appeared to the OIG to be more developed and routine within the facility and among staff.

Problem Identification and Resolution Processes

In a complex, high-risk healthcare environment, organizations must be efficient problem solvers. The OIG evaluated problem identification and resolution processes at Facilities A and B in the context of two HRO principles—Deference to Expertise and Commitment to Resilience.

⁶⁵ Patient Safety & Quality Healthcare, "Communication: A Critical Healthcare Competency," November 6, 2017, accessed December 11, 2020, <https://www.psqh.com/analysis/communication-critical-healthcare-competency>.

⁶⁶ According to the Facility A Director, the Daily Management System (DMS) huddle is a formalized communication process that disseminates information throughout the organization daily. The DMS process has layers of performance including the service chiefs' DMS huddle and the ELT DMS huddle. The goal is problem solving at the frontline level; however, if the challenges cannot be resolved there, they are elevated to the service line chiefs up to the ELT level.

The HRO principle of **Deference to Expertise** states that on-the-ground subject matter experts are essential for urgent situational assessment and that decisions about how to deal with problems are made by those experts. The World Economic Forum asserts that “complex problem solving” is about enabling and supporting knowledgeable staff to collaborate and find solutions.

Interviews reflected that leaders across both facilities believed that they sought input and participation from frontline staff and that they empowered employees to problem solve and bring improvement ideas forward. They also described similar approaches to ensure staff inclusion in these activities.

Facility A

Facility A was developing processes to enhance frontline employee participation in problem identification and resolution, but further work was needed to promote inclusion and empowerment at this level.

Several leaders reported implementation of a Daily Management System (DMS) “enterprise huddle” in January 2019, which was attended by 70–80 employees. The goal is to problem solve at the frontline staff level, but when those efforts are not successful, the problem or challenge is elevated to the service chief, ELT, and Subject Matter Expert Board for action and follow-up. Nevertheless, one Facility A leader told the OIG that when developing workgroups, service chiefs, section chiefs, and other senior leaders were appointed to head focus reviews (also called leadership reviews) and strategic planning sessions. While frontline staff served on focus groups, they were reportedly chosen by the service or section chiefs and were not routinely the workgroup leaders. Therefore, the quality, inclusiveness, and empowerment of some workgroups was dependent on the interest and engagement of the chief. As noted in the Leadership section of this report, not all service and section chiefs were viewed as strong or accountable by ELT members. For example, one leader confirmed that efforts to resolve a staffing issue in one clinical area did not initially include frontline staff from that area.

Facility B

In general, Facility B leaders echoed the Director’s statement that it was not a top-down organization and reported that the facility engages in after-action reviews to get feedback from the involved staff. The previous COS said that the facility approached “more global” issues by identifying team members with the relevant expertise, and then “throw[ing] them in a room and say[ing] you all figure it out.” The previous COS also described an employee engagement event where about 400 staff members signed up for improvement work groups to address certain areas that had previously been identified through employee polling.

Resilience and Innovation

The HRO principle of **Commitment to Resilience** centers around an organization’s ability to cope with unexpected events and innovate solutions “within a dynamic environment.”

The OIG questioned staff at each facility concerning their response to the COVID-19 pandemic, which likely meets most people’s definition of an unexpected event. The OIG learned through interviews that both facilities approached and managed the significant challenges related to COVID-19 in similar ways, including implementing their incident command centers; engaging their subject matter experts in prioritizing and directing activities; holding frequent briefings and planning sessions; and coordinating and communicating with anxious staff and patients.

Of note, the Facility B Director reflected that [the facility at large] handles unexpected events and everyday business mostly the same—by bringing “smart people around the table,” and further noted the facility’s goal is to take something as unexpected as COVID-19 and not lose “our way in terms of our process of transparency and communication with our staff.”

The OIG found that leaders’ perspectives about innovation within their respective facilities was further evidence of where each landed on the HRO maturity spectrum.

Facility A

The Facility A Director told the OIG on several occasions that staff feared taking risks, which was described as staff being reluctant to take actions or implement processes outside of a rigid, by-the-book approach. The Director attributed this fear to the high level of scrutiny by the OIG and staff perceptions that taking risks could result in disciplinary action, and noted that this type of risk aversion can limit a facility’s growth. Nevertheless, other leaders told the OIG of having business meetings with services where innovative ideas are encouraged and discussed, as well as about efforts to support innovation awards.

Facility B

Facility B leaders were positive about the level of innovation and risk taking. One ELT member commented about “how nimble” the staff were when changes were in the interest of patients, and another said that giving staff the opportunity to innovate and “make it theirs” had been a factor in strong employee retention. An example of innovation involved a 3-D printing shop, which started with the purchase of a used 3-D printer from another VHA facility, evolved to acquiring 30 3-D printers, and later becoming one of VHA’s top sites for printing COVID-19 testing swabs.

4. Human Resource Management

According to Human Resources for Health, there is general acceptance within the healthcare community that high staff turnover and vacancy rates negatively affect access to care, quality of care, and patient safety, as well as patient and staff satisfaction.⁶⁷ In this review, the OIG

⁶⁷ J. Buchanan, “Reviewing the Benefits of Health Workforce Stability,” *Human Resources for Health*, 2010; 8:29, accessed August 20, 2020, <https://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-8-29>. VHA Research Series: *The Business Case for Work Force Stability* 2002, accessed August 20, 2020, <https://www.leg.state.nv.us/Session/72nd2003/Interim/StatCom/HealthCareDelivery/exhibits/11617K.pdf>.

identified two important human resource-related factors that contribute to an organization's ability to provide services efficiently, effectively, and safely. Those factors were the strength of human resource staffing and processes and the degree of registered nurse turnover.

Brief History of Human Resource Services and Modernization

Prior to October 2018, the full range of personnel-related services, including recruitment and hiring, were generally provided by human resource staff located within each VHA facility. In that model, facility human resource departments were responsible for the delivery of all services and oversight of staff. As such, the quality and efficiency of services were dependent on the human resource department having the right number of staff with the appropriate skill sets, as well as qualified managers to oversee human resource operations.

In October 2018, VHA initiated the Human Resource Modernization and Shared Services Unit model (Human Resource Modernization), which consolidated transactional services (such as Employee and Labor Relations and Worklife Benefits) and realigned facility human resource operations under the VISN Human Resource Officer.⁶⁸ In this model, a cadre of facility-level human resource staff continue to provide specified staffing services and other day-to-day support for matters at their respective facilities. Complete implementation of Human Resource Modernization across VHA was planned for 2020. The OIG noted that, as with any large-scale realignment, the transition to, and staffing of, a fully developed Human Resource Modernization program is taking time and is encountering obstacles. According to the VISN Human Resource Officer, Human Resource Modernization in the VISN was progressing slowly.

Human Resource Staffing and Processes

Human resource staff at both facilities reported shortages of facility-level Human Resource personnel to support recruitment and placement activities. Further, each facility reported using similar recruitment and hiring incentives to address hiring challenges.

Facility A

A Facility A Human Resource manager told the OIG that with Human Resource Modernization personnel realignments, the Human Resource employees assigned to support staffing activities within the facility were insufficient. Reportedly, the facility recognized the need and hired four additional Human Resource position management specialists to improve the timeliness of recruitment and hiring.

⁶⁸ VA Executive in Charge, "Veteran Integrated Service Networks (VISN) HR Modernization and Shared Services Implementation," October 3, 2018. The modernization strategy was to "realign reporting structures, consolidate transactional services, create strategic partnerships with local resources, and establish Centers of Excellence (CoE) to promote consistent implementation of best practices in HR management at VHA."

The COS told the OIG that mental health providers were the facility's biggest recruitment priority, and the facility was working with the VHA National Recruitment Consultant and using websites such as Practice Link to advertise nationally. The Assistant Human Resource Manager reported that the facility used relocation and recruitment incentives for hard-to-fill positions, and education debt reduction for staff retention. Further, Facility A was able to use approved COVID-19 rapid hire processes and telework options to increase staffing.

While Facility A leaders reported continued difficulty recruiting some clinical specialists, progress was being made.⁶⁹ In March 2021, the COS reported filling multiple primary care vacancies in the previous six months, including three through an arrangement with the US Public Health Service. Additionally, Facility A was successful in hiring diagnostic radiology staff in 2019 and surgery, pharmacy, and psychology staff in 2020.

Facility B

A Facility B Human Resource Manager told the OIG that with Human Resource Modernization personnel realignments, the Human Resource employees assigned to support recruitment and placement activities within the facility had been reduced from 14 to 5 FTE, and as a result, actions were taking longer and some hiring opportunities for providers were lost. To address this deficit, other facilities within the VISN were assisting with physician recruitments and filling licensed practical nurse vacancies.

The previous long-term COS reported that it could be challenging to hire specialty clinicians who were paid at a higher salary rate in the community such as cardiothoracic and neurosurgery, a condition echoed by the Assistant Human Resource Manager. Facility B used contracted and part-time staff from the academic affiliate to meet specialty care demands, as needed. The previous COS told the OIG that otherwise, the facility did not have difficulty hiring clinical providers.⁷⁰ Facility B reported using recruitment, retention, and relocation incentives, including VA's National Education Debt Reduction Program for hard-to-fill positions, to address provider

⁶⁹ While Facility A is located in an area with many appealing qualities and amenities, some leaders acknowledged that it was not a destination that would attract clinical providers and other higher-level staff. Further, Facility A employees did not receive locality pay; however, the cost of living in the area was lower than the average cost of living in the US in 2021. The OIG noted several hospitals in the same area as Facility A, which were sources of competition for qualified staff.

⁷⁰ The Facility B Director explained that although in a desirable location, the cost of living and VHA's inability to accommodate private sector equitable pay could present a challenge for recruitment and retention in some positions. The Assistant Director expressed that entry-level and lower-wage positions were more impacted by the high cost of living. Locality pay was not included in the salary structure for federal employees living in the area surrounding Facility B, and the cost of living in 2021 was slightly higher than the national average. There were several hospitals in the same area, which were sources of competition for qualified staff.

vacancies.⁷¹ Facility B was successful in hiring mental health, geriatrics and extended care, and pathology and laboratory staff in 2019, and surgery staff in 2020.

Registered Nurse Turnover and Retention Efforts

One established metric of retention is the registered nurse turnover rate, which measures losses of registered nurses. Registered nurse turnover is a key indicator in healthcare organizations recognized for quality patient care, nursing excellence, and innovations in professional nursing practice. Registered nurse turnover rates are calculated based on permanent employees who quit or were terminated and can provide insight into a facility's ability to retain experienced nursing staff. Facility registered nurse turnover calculations do not include retired registered nurse data.⁷²

Facility A

VHA data reflected a dramatic increase in Facility A's registered nurse turnover rate for the 12 months beginning June 2019. Specifically, from June to July 2019, registered nurse turnover increased from 6.7 percent to 12.3 percent and remained above 10 percent through June 2020. The acting ADPCS had reportedly not fully explored the reasons for high nursing turnover during this time. The acting ADPCS told the OIG of initiating a risk assessment workgroup with nursing, human resources, and the reasonable accommodations coordinator to address administrative issues; implementing a revised staffing methodology; and implementing a process improvement project to address the issue of balanced work schedules of frontline nursing staff. Further, the acting ADPCS said the facility has continued to evaluate processes surrounding nurse onboarding, staffing, and time-off reviews.

According to the Director, Facility A implemented a three-day hiring process to increase the number of nurses, taking advantage of COVID-19 rapid hire processes to onboard nursing staff. The Assistant Human Resource Manager reported that new salary charts were created to retain registered nurses in specialty areas like critical care and spinal cord injury. In July 2020, the registered nurse turnover rate had substantially improved to about 6 percent, through February 2021.

Based on interviews, it did not appear to the OIG that Facility A broadly employed a shared governance structure, which allows nursing staff to work collaboratively and share responsibility

⁷¹ Facility B Incentives from VA Flyer "Care for Veterans and Earn a Debt-Free Degree," VA offers up to \$200,000 over a five-year period for certain direct-care positions.

⁷² "The Strategic Analytics for Improvement and Learning (SAIL) Value Model Data Definitions." Facility quit rate, also called "regrettable losses," is defined as "voluntary resignations and transfers out of the selected facility. This turnover rate is especially important to analyze since these losses are voluntary and potentially preventable." Termination rate is defined as "terminations including resignations and retirements in lieu of termination, but excluding losses to military, transfers and expired appointments." The registered nurse turnover data excludes advanced practice nurses, clinical nurse specialists, students, trainees, intermittent staff, fellows, and registered nurses who retire.

for making decisions that affect their nursing practice. Nursing staff engagement and a sense of empowerment to affect change can result in improved patient outcomes and increased job satisfaction.

Facility B

The Assistant Human Resource Manager told the OIG that Facility B did not have difficulty hiring registered nurses, and the OIG's review of VHA data revealed that Facility B's registered nurse turnover rate had largely remained steady over the past several years, ranging from 4.5 percent to 6.8 percent. A Facility B leader attributed the fluctuating registered nurse turnover rate to four hospitals in the same community competing for the same highly trained nurses. The Facility B Director told the OIG that some nurses apply to and onboard at Facility B, then resign their positions for opportunities at other area facilities, including VHA facilities. The Facility B ADPCS also told the OIG about available opportunities such as tuition reimbursement and transition to practice training programs, which could result in better-than-average retention rates. Facility B used a shared nursing governance structure, AES results were provided to staff and posted in a common area, and staff were invited to participate in developing action plans to address deficiencies.

5. Key Take-Away from the Review

Most facilities can and should identify, evaluate, and address opportunities to improve patient care and safety within their organization. However, some VHA facilities, such as Facility A that have been chronic lower performers, have experienced high leadership turnover and challenges to recruiting permanent, high-caliber managers and leaders. These challenged facilities may benefit from more proactive VISN support that begins with a careful examination of leadership, the strength of the QSV program, and the integration of HRO principles.

6. Suggestions for VISN Consideration

The purpose of this review was to evaluate select aspects of operations and performance at Facilities A and B within the same VISN. As this was not a traditional compliance or quality review, the OIG did not make recommendations. Rather, using these two facilities as models, the OIG attempted to identify opportunities for VISN X to provide meaningful and timely assistance to struggling facilities, which are posed as questions for VISN consideration. In this context, the OIG suggests VISNs evaluate whether it would be productive to

- assign mentors to new and existing leaders of chronically underperforming facilities;
- require National Center for Organizational Development evaluation of leadership and performance, including psychological safety and Just Culture, which could provide a road map of priority items and actions;
- charter external evaluation and development teams when certain metrics “trigger,” reflecting that facility-based actions, if any, have been unsuccessful;
- develop a mechanism whereby retired VHA leaders with experience and established track records could be used for assignments at underperforming facilities;
- require facilities to establish and routinely report on leadership development and succession planning activities;
- prioritize development of new guidelines and a national directive to support a coordinated organizational quality and safety program to align with current lanes of efforts, high reliability, and modernization;
- provide a staffing methodology or general guidance for the department responsible for quality management-related issues, Systems Redesign, and HRO integration to promote efficiency and minimize duplication of efforts; and
- offer mentoring and training opportunities emphasizing the importance and intent of robust committee meeting minutes in each facility’s journey toward high reliability, and outline baseline quality expectations relative to meeting minute documentation.

Appendix A: Measures and Weights in the SAIL Model

Composite	Domain (Weight)*	Measure	Weight (percent)*
Quality	Acute Care Mortality (12 percent)	In-hospital Standardized Mortality Ratio (SMR)*	6.0
		30-Day SMR	6.0
	Avoidable Adverse Events (12 percent)	In-Hospital Complications*	6.0
		Healthcare Associated Infections	6.0
		Inpatient-Post Acute Care Events*	0.0
		Patient Safety Indicators	0.0
	Length of Stay and Throughput (12 percent)	Adjusted Length of Stay	7.2
		% Admit and Continued Stay Reviews Met	4.8
		Emergency Department Throughput	0.0
	Mental Health (12 percent)	Population Coverage	4.0
		Continuity of Care	4.0
		Experience of Care	4.0
	Performance Measures (8 percent)	ORYX	4.0
		HEDIS EPRP Based	2.4
		HEDIS eQM Based	1.6
	Employee Satisfaction (8 percent)	AES Best Places to Work	4.0
		Registered Nurse Turnover*	4.0
	Patient Experience (12 percent)	Overall Rating of Hospital (Inpatient)	3.0
		Care Transition (Inpatient)	2.0
		Rating of PC and SC Providers**	4.0
		PCMH and SC Care Coordination	2.0
		Stress Discussed (PCMH)	1.0
	Care Transition (12 percent)	Ambulatory Care Sensitive Conditions Hospitalizations	7.2
		All Cause 30-Day Readmissions	4.8
		Excess Days in Acute Care*	0.0
	Access to Care (12 percent)	Timely Appointment, Care, and Information (PCMH and SC)	6.7
		Days Waited for Urgent Care (PCMH)	1.7
		Call Pick Up Speed and Abandonment	3.6
PC, SC, and MH Wait Times		0.0	

Composite	Domain (Weight)*	Measure	Weight (percent)*
Efficiency/ Capacity	Clinical and Administrative Efficiency		N/A
	Physician Capacity		N/A
	Advanced Practice Provider Capacity*		N/A

Source: *OIG SAIL Data Metrics.*

*Beginning with July 1, 2019, these domains and measures no longer apply and are no longer weighted. N/A = not applicable.

**Acronym definitions used in this table: MH = mental health, PC = Primary Care, PCMH = Primary Care Mental Health, SC = Specialty Care

Appendix B: OIG Risk Stratification Model

Medical Center Risk Score Data Elements

All time low performer

- Ranking in the lowest 20 percent in VA for all quarters

Low performer and worsened

- Ranking worse than historical average AND average ranking in the lowest 20 percent in VA over last five quarters
- Ranking in the lowest 20 percent in VA for greater than or equal to (\geq) 5 times over last six quarters

Most declined

- Ranking worsened by 75 positions from the best performance
- Ranking worsened by 50 positions over last six quarters

Decline trend

- Ranking significantly worsened ($>$ upper control limit; exclude High Performing sites)
- Ranking worsened in five of six last quarters and overall worsened ≥ 25 positions
- Ranking continued worsened over last three quarters and overall worsened ≥ 75 positions

Fast track decline

- Quality worsened by 2 levels over last two quarters (such as from Above Average to Below Average)
- Ranking worsened by 50 positions over last two quarters

Other factors

- Number of times assigned Low-Performing quality over last six quarters
- Size of improvement or decline in quality from one year ago
- Metrics improved from last year (sum of metric weights in the 75th or 90th percentile)
- Metrics declined from last year (sum of metric weights in the 75th or 90th percentile)

Medical Center Risk Stratification

High Risk

- All Time Low Performer
- Assigned Low Performing in quality
- Risk Score in the 97.5th percentile or higher

Watch List

- Low Performer and Worsened
- Risk score between 90th and 95th percentile

Moderate Risk

- Risk score in 75th percentile
- Below Average in quality for two consecutive quarters
- Risk Score at the level of High Risk or Watch List, while quality performance was High Performer or Above Average

Average Risk

- All Others

Source: Summary of OIG Risk Stratification Model

Appendix C: Profiles for Facilities A and B

Facility A

Table C.1 includes Facility A’s budget, workload, and clinical staffing data for October 1, 2017, through September 30, 2020.⁷³

**Table C.1. Facility A Profile
October 1, 2017, through September 30, 2020**

Profile Element	Fiscal Year 2018	Fiscal Year 2019	Fiscal Year 2020
Total medical care budget dollars	\$450,446,899	\$478,620,944	\$581,830,488
Number of:			
Unique patients	45,949	46,428	46,020
Outpatient visits	592,919	594,125	546,835
Unique employees	2,076	2,068	2,182

Source: VHA Support Service Center data accessed February 2, 2021, and March 31, 2021.

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

Facility B

Table C.2 includes budget, workload, and clinical staffing data for October 1, 2017, through September 30, 2020.

**Table C.2. Facility B Profile
October 1, 2017, through September 30, 2020**

Profile Element	Fiscal Year 2018	Fiscal Year 2019	Fiscal Year 2020
Total medical care budget dollars	\$573,093,023	\$587,519,366	\$667,912,490
Number of:			
Unique patients	77,781	79,896	77,779
Outpatient visits	960,019	1,022,540	965,707
Unique employees	2,362	2,577	2,762

Source: VHA Support Service Center data accessed February 2, 2021.

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

⁷³ Dates of this review cover fiscal year 2018 through fiscal year 2020 (October 1, 2017–September 30, 2020). This includes employees who were involved in direct medical care.

Appendix D: Office of the Acting Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: October 18, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Descriptive Analysis of Select Performance Indicators at Two Healthcare Facilities in the Same Veterans Integrated Service Network

To: Assistant Inspector General for Healthcare Inspections (54)
Director, Office of Healthcare Inspections (54RR00)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Descriptive Analysis of Select Performance Indicators at Two Healthcare Facilities in the Same Veterans Integrated Service Network. The Veterans Health Administration (VHA) finds OIG's approach to evaluating this performance extremely helpful in assessing our work and ensuring the quality and consistency of the services we provide. We appreciate this effort and are confident it will serve as a valuable guide for our continued improvement well into the future.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D.

OIG Contact and Staff Acknowledgments

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