DEPARTMENT OF VETERANS AFFAIRS

**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Comprehensive Healthcare Inspection Summary Report: Evaluation of Leadership and Organizational Risks in Veterans Health Administration Facilities, Fiscal Year 2020

CHIP REPORT | REPORT #21-01524-43 | DECEMBER 14, 2021


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***Figure 1.*** *Veterans Affairs Building, Washington, DC.*
*(Source: https://www.gsa.gov/, accessed on June 24, 2021).*

# Abbreviations

| | |
|---|---|
| ADPCS | Associate Director for Patient Care Services |
| CHIP | Comprehensive Healthcare Inspection Program |
| OIG | Office of Inspector General |
| SAIL | Strategic Analytics for Improvement and Learning |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years. The OIG selects and evaluates specific areas of focus each year.

The purpose of this report is to provide a descriptive evaluation of VHA facility leadership performance and effectiveness as evidenced by quality care, organizational risks, patient outcomes and experiences, and employee engagement and satisfaction.

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with facility leaders and staff, and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA leaders' performance at the time of the fiscal year 2020 OIG reviews. They should be considered when improving operations and healthcare quality and mitigating organizational risks.[1]

## Inspection Results

The OIG found that 90 percent of executive leadership positions were filled by permanent staff at the time of the inspections. The OIG determined that nearly half of the leaders interviewed at the 36 inspected medical facilities had an overall tenure of not more than two years, and less than 20 percent of the leaders had over five years of tenure in their positions. Leaders generally appeared to be engaged with quality, safety, and value activities at their facilities. Leaders reported feeling supported by Veterans Integrated Service Network leaders and program managers, and using public or private sector expert resources for guidance and assistance with quality, safety, and value initiatives. Further, most facility leaders were actively involved in maintaining accreditations and addressing The Joint Commission and OIG recommendations for improvement and organizational risks.

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning Value (SAIL) Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[2] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within

[1] Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

[2] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center (VSSC). At the time of publication, this office had been renamed the Office of Analytics and Performance Integration.

VHA.[3] Facility leaders were generally knowledgeable about applicable under-performing SAIL performance metrics for their facilities and community living centers, and could speak about actions taken to improve their performance.

The OIG noted that facilities with higher complexity levels had more sentinel events. This observation is not surprising given the complex clinical programs, volume of high-risk patients, and teaching program affiliations at high complexity facilities. However, the OIG noted the opposite for institutional disclosures. This might be attributed to one medium complexity facility that reported a large number of institutional disclosures. On average, high and medium complexity facilities generally received more CHIP recommendations than low complexity facilities.

## Conclusion

The OIG conducted detailed inspections at 36 VHA facilities to provide a descriptive evaluation of VHA facility leadership performance and effectiveness. The OIG did not issue recommendations but developed this summary report for the Under Secretary for Health, Veterans Integrated Service Network directors, and facility senior leaders to consider when improving operations and clinical care at VHA facilities.

## Comments

The Acting Under Secretary for Health concurred with the comprehensive healthcare inspection report (see appendix C, page 18). The OIG responded to the request for change in an addendum to appendix C.

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[3] "Strategic Analytics for Improvement and Learning (SAIL) Value Model."

# Contents

# Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

The purpose of this report is to provide a descriptive evaluation of VHA facility leadership performance and effectiveness. While the OIG selects and assesses specific areas of focus on a rotating basis each year, the evaluation of VHA facilities' leadership and organizational risks is an ongoing review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.[1] These leaders are directly accountable for program integration and communication within their level of responsibility.

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can affect a facility's ability to provide care in clinical focus areas.[2] To assess facility-level risks, the OIG considered the following indicators:

- Executive leadership position stability and engagement
- Accreditation surveys and oversight inspections
- Identified factors related to possible lapses in care and facility leaders' responses
- VHA performance data (facilities and community living centers)[3]

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with facility leaders and staff and reviews of clinical and administrative processes.

The results in this report are a snapshot of VHA leaders' performance at the time of the fiscal year 2020 OIG reviews and should be considered when improving operations and healthcare quality and mitigating organizational risks.[4]

[1] Pub. L. 111-163, 124 Stat. 1130 as amended (codified at 38 U.S.C. § 1720G).
[2] Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper, 2006.
[3] In VA, a nursing home is referred to as a community living center.
[4] Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

# Methodology

To determine whether VHA facilities implemented and incorporated selected leadership and organizational risk mitigation processes into local activities, the OIG reviewed survey results, human resource information, and findings and recommendations from inspections since the previous CHIP, Combined or Clinical Assessment Program, and community-based outpatient clinic reviews. Additionally, the OIG interviewed senior managers and key employees and evaluated accreditation or for-cause surveys and oversight inspections, factors related to possible lapses in care, and VHA performance data.[5]

The 36 facilities reviewed during fiscal year 2020 represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). The OIG published individual CHIP reports for each facility. For this report, the OIG aggregated and analyzed data from the individual facility reviews to identify system-wide trends.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[5] The OIG did not review VHA's internal survey results and instead focused on OIG inspections and external surveys that affect facility accreditation status.

[6] Pub. L, No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

# Results and Recommendations

## Executive Leadership Position Stability and Engagement

The OIG performed this review at facilities representing five VISNs and all complexity levels (see appendix B, tables B.1 and B.2).[7] Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population it serves, organizational structures may differ across facilities. The most common team composition (16 of 36 facilities) included a director, chief of staff, associate director for patient care services (ADPCS), and associate director (primarily nonclinical). The OIG observed that the next most common team composition (14 of 36 facilities) included an additional assistant director (see appendix B, table B.3). The chiefs of staff and ADPCSs oversaw patient care, which required managing service directors and chiefs of programs.

During each comprehensive healthcare inspection, the OIG collected human resource data pertaining to the leadership team, which indicated whether the positions were permanently occupied and each leader's tenure. For the 166 leadership positions reviewed, 149 positions (90 percent) were filled by permanent leaders, while leaders in 17 positions (10 percent) served in an interim capacity. The 17 positions filled by interim leaders included six facility directors, four chiefs of staff, two ADPCSs, and five associate directors (see appendix B, table B.4).

Among the permanently assigned leaders, the OIG noted variations in their tenures at the time of the comprehensive healthcare inspections. Thirty permanently assigned facility directors served in their positions for an average of 3.2 years; tenure ranged from approximately 9 weeks to just over 12 years. The OIG also noted that 32 chiefs of staff served in their roles an average of 4.4 years. The newest chief of staff had been in the role for just over 1 week, and the most experienced had served for over 22 years.

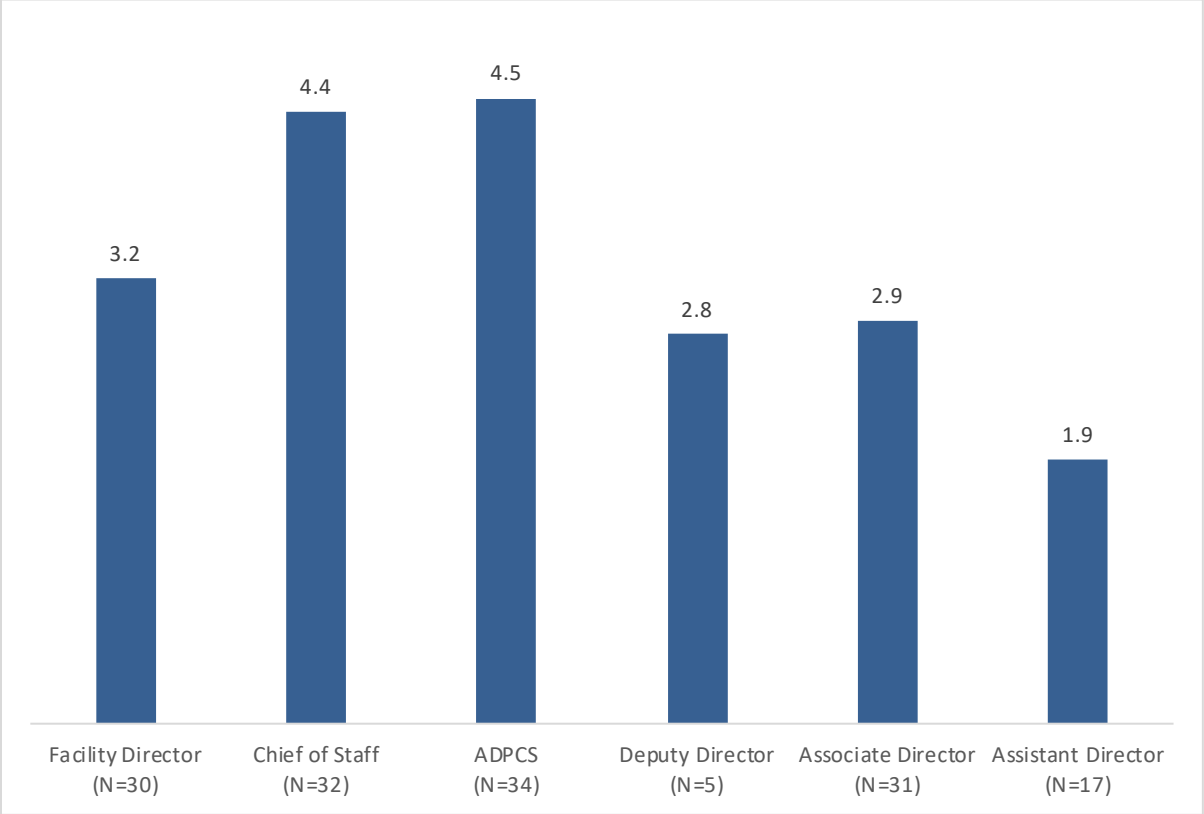
The OIG found a range of tenures for the ADPCSs, deputy directors, associate directors, and assistant directors. The 34 ADPCSs appeared to be the most stable among this group, having served in their roles an average of 4.5 years. The newest ADPCS was on the job for approximately 6 weeks and the most experienced had served for over 24 years. The OIG also found that 5 deputy directors, 31 associate directors, and 17 assistant directors had served in their positions an average of 2.8, 2.9, and 1.9 years, respectively. The deputy directors' tenures ranged from approximately 1.3 to 7.3 years, the associate directors' tenures ranged from approximately

[7] "Facility Complexity Model," VHA Office of Productivity, Efficiency, & Staffing, accessed June 14, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) "[T]he Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex." Facility groupings are used for various peer grouping purposes, such as operational reporting, performance measurement, and research studies.

4 days to almost 13.9 years, and the assistant directors' tenures ranged from approximately 4 months to just over 7.6 years (see figure 2 and appendix B, table B.5).

While conducting fiscal year 2020 comprehensive healthcare inspections, the OIG found that nearly half of the permanently assigned leaders interviewed at the 36 inspected VA medical facilities had an overall tenure of two years or less. These leaders may not yet fully understand the landscape of their current positions and may still need to gain the skills to help navigate the constant challenges of managing people and change at their facilities. Additionally, less than 20 percent of the interviewed leaders had over five years of tenure in their positions (see appendix B, table B.6). Recent retirements and resignations may have played a role, but VHA's practice of leadership reassignments can have negative effects with respect to tenure length. VHA can be pivotal in stabilizing the leadership workforce and influencing the success of these leaders and the provision of quality care.

**Figure 2. Average Tenure by Executive Leader at Time of CHIP Visit (in Years)**




*Source: VA OIG.*

To help assess the executive leaders' engagement, the OIG interviewed directors, chiefs of staff, ADPCSs, associate directors, and some assistant directors regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain

performance. Members of the executive leadership team were generally knowledgeable about relevant performance metrics.

During interviews, the OIG assessed facility directors' participation and engagement with quality, safety, and value activities; and whether they felt supported by VISN leaders and had access to external resources for performance improvement activities. During interviews, facility directors reported spending between 5 and 40 hours per week supporting quality, safety, and value and improvement activities by holding discussions with the chief of quality to address concerns, conducting purposeful rounds, and participating in meetings.[8]

When asked about the level of VISN support for quality improvement activities, all 35 facility directors who were interviewed indicated that VISN leaders provided more than adequate support.[9] The OIG noted that 33 of 35 facility directors (94 percent) reported using public or private sector resources, such as The Joint Commission, American College of Healthcare Executives, and Medical Group Management Association for guidance with quality improvement.[10]

"As part of its ongoing modernization efforts, VA is launching a new electronic health record (EHR) system to store and track patient medical information, with full implementation across all VA facilities scheduled for completion by 2028. Through this effort, known as the Electronic Health Record Modernization (EHRM) program, VA is implementing one of the most advanced EHRs in the country."[11] The transition is one of VA's top priorities and scheduled to occur over a 10-year period, which began in the Pacific Northwest in 2020. The OIG interviewed facility leaders to gather preliminary information on VHA's efforts to mitigate identified risks associated with the implementation. During the transition, the new electronic health record system may affect facilities' ability to provide timely care due to system instability, need for workarounds, poor usability, and unfamiliarity with the system. The OIG recognizes the enormous and challenging effort to convert electronic health record systems and acknowledges the significant work and commitment of VA staff to accomplish this task.

Facility leaders provided a range of responses when asked when their facility would implement the new system. Some facility leaders knew the exact year, while others were unable to provide a time frame. When asked whether communication from the Office of Electronic Health Record

[8] Responses included percentages of time, percentage ranges, and numbers of hours per week spent supporting quality, safety, and value and improvement activities. The Director at the VA St. Louis Health Care System in Missouri was not interviewed.

[9] One facility director was not interviewed (VA St. Louis Health Care System in Missouri).

[10] Two facility directors' responses (Boise VA Medical Center in Idaho and VA Roseburg Health Care System in Oregon) did not clearly address the question or could not answer on access to public or private sector expert resources for guidance in quality, safety, and value and improvement activities. One facility director was not interviewed (VA St. Louis Health Care System in Missouri).

[11] "What is EHRM," VA EHR Modernization, accessed October 25, 2021, https://www.ehrm.va.gov/about/whatis.

Modernization was adequate, 87 facility leaders answered affirmatively, 27 indicated that communication was inadequate, and 2 were too new in their positions to answer. Lastly, leaders were asked if they had concerns regarding the new electronic health record rollout—102 expressed concerns, 2 stated it was too early to say, 38 voiced no concerns, 3 reported lack of knowledge, and 4 did not answer. This highlights the importance of communication to mitigate potential challenges related to the electronic health record system transition.

## Accreditation Surveys and Oversight Inspections

The OIG noted that 29 of 36 facilities had received College of American Pathologists inspections since the previous OIG cyclical review.[12] Twenty-six facilities also received accreditation from the Commission on Accreditation of Rehabilitation Facilities for at least one rehabilitation program.[13] Additionally, 33 of the 36 facilities underwent Long Term Care Institute inspections, and 5 of the 36 facilities were surveyed by the Paralyzed Veterans of America.[14]

At the time of inspection, eight facilities had open recommendations from previous OIG Combined Assessment Program, Clinical Assessment Program, CHIP, and community-based outpatient clinic inspections.[15] From the time of the previous OIG reviews, the 36 facilities were subject to 17 OIG hotline inspections that resulted in 134 recommendations. For 52 recommendations that remained open at the time of the CHIP visits, the OIG found that

[12] "About the College of American Pathologists," College of American Pathologists, accessed October 10, 2021, https://www.cap.org/about-the-cap. According to the College of American Pathologists, for 75 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." Additionally, as stated in VHA Directive 1106, *Pathology and Laboratory Medicine Service*, July 27, 2018, VHA laboratories must meet the requirements of the College of American Pathologists. The seven facilities that did not receive a College of American Pathologists survey were not due for a survey since the previous OIG cyclical review.

[13] VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment "is supported through a system-wide, long-term joint collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs." The 10 facilities that did not receive a Commission on Accreditation of Rehabilitation Facilities inspection either were not due for an inspection since the previous OIG cyclical review or did not have an accredited program.

[14] "About Us," Long Term Care Institute, accessed October 12, 2021, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement; compliance program development; and review in long term care, hospice, and other residential care settings." The three facilities that did not receive a Long Term Care Institute survey since the previous OIG cyclical review either were not due or did not have a community living center. The Paralyzed Veterans of America does not result in accreditation status. The 31 facilities that did not receive a Paralyzed Veterans of America survey since the previous cyclical OIG review either were not due or did not have a spinal cord injury unit.

[15] The eight facilities that had open recommendations at the time of the CHIP visit were: Charlie Norwood VAMC (Augusta, Georgia); Jesse Brown VAMC (Chicago, Illinois); Carl Vinson VAMC (Dublin, Georgia); Edward Hines, Jr. VA Hospital (Hines, Illinois); Oscar G. Johnson VAMC (Iron Mountain, Michigan); Kansas City VAMC (Kansas City, Missouri); William S. Middleton Memorial Veterans Hospital (Madison, Wisconsin); and Tuscaloosa VAMC (Tuscaloosa, Alabama).

insufficient time had passed to initiate follow-up, or facility leaders were still actively engaged in addressing the recommendations or were still monitoring for sustained improvement.

The OIG also found that 28 of the facilities received routine, unannounced inspections from The Joint Commission—one of which had been recently completed, and the facility was actively addressing recommendations for improvement.[16] The OIG also found that four medical centers underwent for-cause inspections by The Joint Commission since their previous OIG cyclical review.

## Identified Factors Related to Possible Lapses in Care and Facility Leaders' Responses

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, and predictive factors may include lapses in the standard of care. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Careful investigation and analysis of patient safety events (events not primarily related to the natural course of the patient's illness or underlying condition), as well as evaluation of corrective actions, is essential to reduce risk and prevent patient harm.

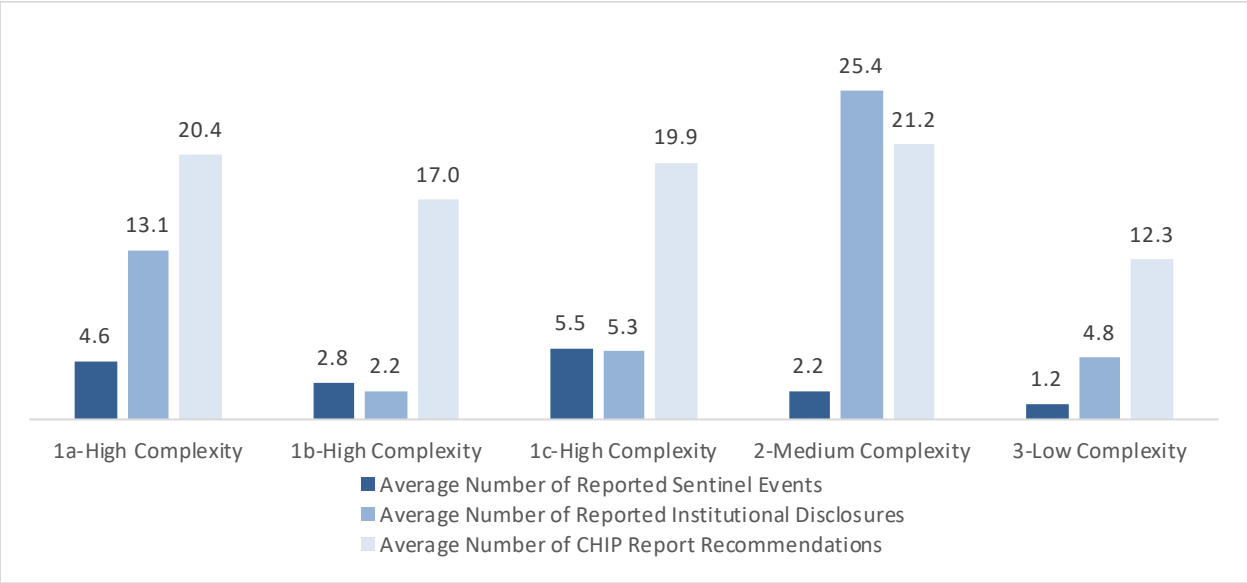
The culture of the organization affects the reporting of patient safety events within the organization. Low numbers do not necessarily mean that facility staff provide good care, and high numbers do not necessarily mean that they provide poor care. If there is a safe culture in an organization, one may see high numbers because staff feel safe coming forward to report that an adverse event has occurred. One would expect leaders to implement a non-punitive environment and address system issues and human factors to correct the situation so that the adverse event does not occur again.

The OIG reviewed the number of facility-reported sentinel events, institutional disclosures, and large-scale disclosures since the facilities' previous OIG cyclical review. Twenty-six facilities reported a total of 121 sentinel events (ranging from 1 to 28), with 17 reporting 2 or more events (see appendix B, tables B.7 and B.9). Thirty-two of the 36 facilities also reported a total of 341 institutional disclosures, ranging from 1 to 115 (see appendix B, tables B.8 and B.10). Additionally, none of the facilities reviewed reported conducting large-scale disclosures.

The OIG observed that lower complexity facilities generally had fewer reported sentinel events than higher complexity facilities (see appendix B, table B.9).

[16] The eight facilities that had not undergone an inspection from The Joint Commission since the previous OIG cyclical review were not due for an inspection.

**Figure 3. Observed Trends by Facility Complexity**




*Source: VA OIG.*

*Note: Some facilities had multiple divisions and may have different complexities across divisions. The OIG used the complexity of the parent facility.*

## Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[17] The OIG assessed the leaders' level of engagement with improvement activities involving SAIL data.[18] When asked about facility-specific and poorly performing metrics, leaders were generally able to discuss the cause as well as actions taken or currently underway to improve performance.[19]

[17] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center. At the time of publication, this office had been renamed the Office of Analytics and Performance Integration.

[18] The OIG assessed facility leaders' responses to specific questions using a scale of 1–5, where a score of 1 indicates the interviewee had no answer or could not provide a substantive response and a 5 indicates that the interviewee provided a thorough response that included in-depth understanding of the metric/question, several facility-based examples to support knowledge, and was able to speak knowledgeably about content and improvement actions.

[19] The averages of the scores assigned by the OIG to the interviewed leaders' responses for factors affecting the two selected SAIL metrics were 3.3 and 3.1. The averages of the scores assigned by the OIG to the interviewed leaders' responses for actions taken to improve performance of the two selected SAIL metrics were 3.5 and 3.4.

## Leadership and Organizational Risks Conclusion

The OIG reviewed leadership and organizational risks at the 36 VA facilities inspected between November 4, 2019, through September 21, 2020. Ninety percent of leadership positions were filled by permanent staff at the time of their respective inspections. Nearly half of the leaders interviewed at the 36 inspected VA medical facilities had an overall tenure of not more than two years, and less than 20 percent of the leaders had over five years of tenure in their positions. Facility directors participated in and appeared to be engaged with quality, safety, and value activities. Examples provided include discussions with the chief of quality to address concerns, conducting purposeful rounds, and participating in meetings. The directors also generally reported feeling supported by VISN leaders and program managers and using public/private sector expert resources for guidance and assistance with quality improvement activities. The facility directors reported The Joint Commission, and membership in American College of Healthcare Executives and Medical Group Management Association as their resources.[20] Members of the executive leadership team were generally knowledgeable about relevant performance metrics. Further, most facility leaders demonstrated active involvement in maintaining various accreditations, addressing The Joint Commission and OIG recommendations for improvement, and taking actions in response to potential organizational risks.

The OIG found that leaders were generally knowledgeable about their facilities and various performance metrics and could speak to actions taken to improve their respective facility's performance. The OIG observed that lower complexity facilities had fewer reported sentinel events than higher complexity facilities (see appendix B, table B.9).

This review of leadership and organizational risks was descriptive in nature, and the results should be interpreted in that context.

[20] Two facility directors' responses (Boise VA Medical Center in Idaho and VA Roseburg Health Care System in Oregon) did not clearly address the question or could not answer on access to public or private sector expert resources for guidance in quality, safety, and value and improvement activities. One facility director was not interviewed (VA St. Louis Health Care System in Missouri).

# Appendix A: Parent Facilities Inspected

**Table A.1. Parent Facilities Inspected in FY 2020 (October 1, 2019, through September 30, 2020)**

| Names | City |
|---|---|
| VA Ann Arbor Healthcare System | Ann Arbor, MI |
| Charlie Norwood VA Medical Center | Augusta, GA |
| Battle Creek VA Medical Center | Battle Creek, MI |
| Birmingham VA Medical Center | Birmingham, AL |
| Boise VA Medical Center | Boise, ID |
| Ralph H. Johnson VA Medical Center | Charleston, SC |
| Jesse Brown VA Medical Center | Chicago, IL |
| Chillicothe VA Medical Center | Chillicothe, OH |
| Cincinnati VA Medical Center | Cincinnati, OH |
| Harry S. Truman Memorial Veterans' Hospital | Columbia, MO |
| Wm. Jennings Bryan Dorn VA Medical Center | Columbia, SC |
| VA Illiana Health Care System | Danville, IL |
| Dayton VA Medical Center | Dayton, OH |
| Atlanta VA Health Care System | Decatur, GA |
| John D. Dingell VA Medical Center | Detroit, MI |
| Carl Vinson VA Medical Center | Dublin, GA |
| Edward Hines, Jr. VA Hospital | Hines, IL |
| Oscar G. Johnson VA Medical Center | Iron Mountain, MI |
| Kansas City VA Medical Center | Kansas City, MO |
| William S. Middleton Memorial Veterans Hospital | Madison, WI |
| Marion VA Medical Center | Marion, IL |
| VA Northern Indiana Health Care System | Marion, IN |
| Clement J. Zablocki VA Medical Center | Milwaukee, WI |
| Central Alabama Veterans Health Care System | Montgomery, AL |
| Captain James A. Lovell Federal Health Care Center | North Chicago, IL |
| John J. Pershing VA Medical Center | Poplar Bluff, MO |
| VA Portland Health Care System | Portland, OR |
| VA Roseburg Health Care System | Roseburg, OR |
| Aleda E. Lutz VA Medical Center | Saginaw, MI |
| VA Puget Sound Health Care System | Seattle, WA |

| Names | City |
|---|---|
| Mann-Grandstaff VA Medical Center | Spokane, WA |
| VA St. Louis Health Care System | St. Louis, MO |
| Tomah VA Medical Center | Tomah, WI |
| VA Eastern Kansas Health Care System | Topeka, KS |
| Tuscaloosa VA Medical Center | Tuscaloosa, AL |
| Robert J. Dole VA Medical Center | Wichita, KS |

*Source: VA OIG.*

# Appendix B: Summary Results

### Table B.1. Inspected Facilities by VISN

| VISN | Number of Facilities Inspected |
|---|---|
| VISN 7: VA Southeast Network | 8 |
| VISN 10: VA Healthcare System | 8 |
| VISN 12: VA Great Lakes Health Care System | 8 |
| VISN 15: VA Heartland Network | 7 |
| VISN 20: VA Northwest Health Network | 5 |

*Source: VA OIG.*

### Table B.2. Inspected Facilities by Complexity

| Facility Complexity* | Facility Complexity Description | Number of Facilities Inspected |
|---|---|---|
| 1a–Highest Complexity | "[H]igh volume, high risk patients, most complex clinical programs, and large research and teaching programs." | 9 |
| 1b–High Complexity | "[M]edium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs." | 5 |
| 1c–Mid-High Complexity | "[M]edium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." | 8 |
| 2–Medium Complexity | "[M]edium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." | 5 |
| 3–Low Complexity | "[L]ow volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." | 9 |

*Source: VA OIG; "Facility Complexity Model," VHA Office of Productivity, Efficiency, & Staffing.*

** As of the comprehensive healthcare inspection.*

## Table B.3. Composition of Leadership Teams

| Composition* | Number of Leadership Teams* |
|---|---|
| Facility Director, Chief of Staff, ADPCS, and Associate Director | 16 |
| Facility Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director | 14 |
| Facility Director, Chief of Staff, ADPCS, Deputy Director, and Associate Director | 4 |
| Facility Director, Chief of Staff, ADPCS, Deputy Director, Associate Director, and Assistant Director | 1 |
| Facility Director, Chief of Staff, ADPCS, Deputy Director, and Assistant Director | 1 |

*Source: VA OIG.*

**As of the comprehensive healthcare inspection.*

## Table B.4. Facility Leaders Permanently Assigned

| Position | Yes* | Yes (%) | No* | No (%) | Total |
|---|---|---|---|---|---|
| Facility Director | 30 | 83 | 6 | 17 | 36 |
| Chief of Staff | 32 | 88 | 4 | 12 | 36 |
| ADPCS | 34 | 94 | 2 | 6 | 36 |
| Deputy Director | 5 | 100 | –† | –† | 5 |
| Associate Director | 31 | 86 | 5 | 14 | 36 |
| Assistant Director | 17 | 100 | –† | –† | 17 |
| **Overall** | **149** | **89.8** | **17** | **10.2** | **166** |

*Source: VA OIG.*

**As of the comprehensive healthcare inspection.*

*† Not applicable.*

## Table B.5. Average Tenure of Permanent Leaders

| Position | Number of Staff* | Average Tenure (Years)* | Minimum Tenure Observed (Weeks)* | Maximum Tenure Observed (Years)* |
|---|---|---|---|---|
| Facility Director | 30 | 3.2 | 9.1 | 12.3 |
| Chief of Staff | 32 | 4.4 | 1.6 | 22.3 |
| ADPCS | 34 | 4.5 | 6.1 | 24.4 |
| Deputy Director | 5 | 2.8 | 65.1 | 7.3 |
| Associate Director | 31 | 2.9 | 0.6 | 13.9 |
| Assistant Director | 17 | 1.9 | 19 | 7.6 |
| **Overall** | **149** | **3.3** | **13.8** | **14.6** |

*Source: VA OIG.*
**As of the comprehensive healthcare inspection.*

## Table B.6. Distribution of Permanent Leaders' Tenure

| Position | <6 Months* | 6 months–1 year* | 1–2 years* | 2–5 years* | >5 years* | Total |
|---|---|---|---|---|---|---|
| Director | 3 | 4 | 6 | 12 | 5 | 30 |
| Chief of Staff | 6 | 1 | 7 | 9 | 9 | 32 |
| ADPCS | 5 | 4 | 8 | 9 | 8 | 34 |
| Deputy Director | 0 | 0 | 2 | 2 | 1 | 5 |
| Associate Director | 3 | 3 | 7 | 14 | 4 | 31 |
| Assistant Director | 4 | 5 | 3 | 3 | 2 | 17 |
| **Overall** | **21** | **17** | **33** | **49** | **29** | **149** |

*Source: VA OIG.*
**As of the comprehensive healthcare inspection.*

**Table B.7. Occurrence of Sentinel Events across Facilities**

| Number of Reported Sentinel Events | Number of Facilities | Total Sentinel Events |
|---|---|---|
| 0 | 10 | 0 |
| 1 | 9 | 9 |
| 2 | 3 | 6 |
| 3 | 5 | 15 |
| 4 | 1 | 4 |
| 5 | 3 | 15 |
| 6 | 1 | 6 |
| 11 | 1 | 11 |
| 13 | 1 | 13 |
| 14 | 1 | 14 |
| 28 | 1 | 28 |
| **Overall** | **36** | **121** |

*Source: VA OIG.*

**Table B.8. Occurrence of Institutional Disclosures across Facilities**

| Number of Reported Institutional Disclosures | Number of Facilities | Total Institutional Disclosures |
|---|---|---|
| 0 | 4 | 0 |
| 1 | 5 | 5 |
| 2 | 2 | 4 |
| 3 | 6 | 18 |
| 4 | 3 | 12 |
| 5 | 3 | 15 |
| 7 | 3 | 21 |
| 8 | 2 | 16 |
| 9 | 3 | 27 |
| 10 | 1 | 10 |
| 15 | 1 | 15 |
| 28 | 1 | 28 |
| 55 | 1 | 55 |
| 115 | 1 | 115 |
| **Overall** | **36** | **341** |

*Source: VA OIG.*

**Table B.9. Sentinel Events by Facility Complexity**

| Facility Complexity | Number of Sentinel Events* | Number of Facilities* | Average Number of Sentinel Events |
|---|---|---|---|
| 1a–Highest Complexity | 41 | 9 | 4.6 |
| 1b–High Complexity | 14 | 5 | 2.8 |
| 1c–Mid-High Complexity | 44 | 8 | 5.5 |
| 2–Medium Complexity | 11 | 5 | 2.2 |
| 3–Low Complexity | 11 | 9 | 1.2 |
| **Overall** | **121** | **36** | **3.3** |

*Source: VA OIG.*
**As of the comprehensive healthcare inspection.*

## Table B.10. Institutional Disclosures by Facility Complexity

| Facility Complexity | Number of Institutional Disclosures* | Number of Facilities* | Average Number of Institutional Disclosures |
|---|---|---|---|
| 1a–Highest Complexity | 118 | 9 | 13.1 |
| 1b–High Complexity | 11 | 5 | 2.2 |
| 1c–Mid-High Complexity | 42 | 8 | 5.3 |
| 2–Medium Complexity | 127 | 5 | 25.4 |
| 3–Low Complexity | 43 | 9 | 4.8 |
| **Overall** | **341** | **36** | **10.2** |

*Source: VA OIG.*
**As of the comprehensive healthcare inspection.*

## Table B.11. OIG CHIP Report Recommendations by Facility Complexity

| Facility Complexity | Number of CHIP Report Recommendations* | Number of Facilities* | Average Number of CHIP Report Recommendations |
|---|---|---|---|
| 1a–Highest Complexity | 184 | 9 | 20.4 |
| 1b–High Complexity | 85 | 5 | 17 |
| 1c–Mid-High Complexity | 159 | 8 | 19.9 |
| 2–Medium Complexity | 106 | 5 | 21.2 |
| 3–Low Complexity | 111 | 9 | 12.3 |
| **Overall** | **645** | **36** | **18.2** |

*Source: VA OIG.*
**As of the comprehensive healthcare inspection.*

# Appendix C: Office of the Under Secretary for Health Comments

## Department of Veterans Affairs Memorandum

Date: November 15, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Leadership and Organizational Risk in Veterans Health Administration Facilities, Fiscal Year 2020 (Project No. 2021-01524-HI-1154) (VIEWS # 6281453)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Leadership and Organizational Risks in VHA Facilities, FY 2020. The Veterans Health Administration (VHA) concurs with the report.

2. VHA asks OIG to consider the following technical comments to improve the accuracy of the report:

   **Comment 1**

   **Draft location:** page iii, paragraph 5, line 1 and page 9, paragraph 1 under the graph, line 1

   **Current language:** Office of Operational Analytics and Reporting

   **Comment and justification:** Office of Analytics and Performance Integration (API). This is the current office name.

3. VHA asks OIG to consider the following general comments in response to the subject draft report:

   **Comment 1**

   **Draft location:** Page iii, Paragraph 4, line 1

   The report identifies 90% of the leadership positions are hired from internal permanent positions. This reflects the VHA culture of leveraging institutional knowledge and demonstrating support for succession planning and leadership engagement.

**Comment 2**

**Draft location:** Page 4, Paragraph 4 line 3

The Associate Director of Patient Care Service has the longest tenured leadership position representing stability of the Nurse Executive role for an average tenure of 4.5 years.

**Comment 3**

**Draft location:** Page 6, Paragraph 3, Lines 1-12

**Current Language:** As part of its ongoing modernization efforts, VA is launching a new electronic health record (EHR) system to store and track patient medical information. Full implementation across all VA facilities is scheduled over the course of 10 years, with anticipated completion by 2028. Through this effort, known as the Electronic Health Record Modernization (EHRM) program, VA is implementing one of the most advanced EHRs in the country. The EHR transition started in the Pacific Northwest in 2020 and is one of VA's top priorities. OIG interviewed facility leaders to gather preliminary information on VHA's efforts to mitigate identified risks associated with the implementation. During the transition, the new electronic health record system may affect the facilities' ability to provide timely care due to the lack of system stability, need to use workarounds, poor usability, and lack of familiarity with the system. The OIG recognizes the enormous and challenging effort to convert electronic health record systems and acknowledges the significant work and commitment of VA staff to accomplish this task.

**Comment:**

The Department of Veterans Affairs (VA) will further consider these findings as we assess the holistic operational readiness of Veterans Integrated Service Networks (VISN) and facilities for EHRM go-live and sustainment. VHA partners, VA's Office of Electronic Health Record Modernization, and Cerner are working together to establish leadership engagement activities focused on providing awareness of the complexities in transitioning to a new EHR. VA's comprehensive communication strategy ensures clear and consistent messaging throughout deployment. VA has implemented an integrated checklist for facility readiness that will gauge several areas, including proactive assessment of facility morale. Additionally, VA will identify opportunities for facility leadership to preserve and enhance confidence among staff throughout the deployment process. VA is working with local and VISN leadership to ensure facilities are supplemented with personnel to ensure adequate training for new EHR users. Super Users, Informatics Staff

and Subject Matter Experts will be included in workflow adoption activities to provide a comprehensive understanding of future state and differences from the legacy EHR.

4. 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.

## Addendum to the Memorandum: OIG Response

The OIG appreciates the feedback from VHA and provides the following response to the Acting Under Secretary for Health's request for change. The OIG reviewed and considered the request. The Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning Value Model. The OIG does not consider the change to improve accuracy. However, the OIG clarified on page iii, footnote 2 and page 9, footnote 18 that, at the time of publication, the office had been renamed the Office of Analytics and Performance Integration.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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