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 2021

CHIP REPORT | REPORT #22-00817-255 | OCTOBER 25, 2022

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Figure 1. *Veterans Affairs Building, Washington, DC.*

Source: https://www.gsa.gov/real-estate/gsa-properties/visiting-public-buildings/veterans-administration-building (accessed June 24, 2021).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
HCS	Healthcare System or Health Care System
OIG	Office of Inspector General
SAIL	Strategic Analytics for Improvement and Learning
VAMC	VA Medical Center
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 selects and evaluates specific areas of focus each year and 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 as evidenced by quality of care, organizational risks, patient outcomes and experiences, and employee engagement and satisfaction.

The OIG initiated unannounced inspections at 45 VHA medical facilities from November 30, 2020, through August 23, 2021. Each inspection involved interviews with key 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 (FY) 2021 OIG inspections and should be considered when improving operations and healthcare quality and mitigating organizational risks.[1]

Inspection Results

The OIG found that 86 percent of executive leadership positions were filled by permanent staff at the time of the inspections. The OIG determined that over half of the leaders interviewed at the 45 inspected medical facilities had an overall tenure of at least two years. During interviews, facility directors described spending significant time supporting quality, safety, and value and improvement activities. When asked about the level of Veterans Integrated Service Network support for quality improvement activities, 42 of the 45 facility directors indicated that Veterans Integrated Service Network leaders provided adequate support.[2]

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. When asked whether communication from the Office of Electronic Health Record Modernization was adequate, 27 percent of facility directors indicated that communication was inadequate. Additionally, 56 percent of the directors expressed some level of concern with the new electronic health record rollout.

[1] FY 2021 began October 1, 2020, and ended September 30, 2021.

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

The OIG reviewed the medical facilities' FY 2020 annual medical care budget, compared it to the previous year's budget, and asked facility directors about the effect of this change on the facilities' operations and whether the current year's budget (FY 2021) was adequate. VA New York Harbor Healthcare System was the only facility to experience a decrease in its medical care budget from FY 2019 to 2020. Seventy-eight percent of facility directors, including the VA New York Harbor Healthcare System Director, indicated that the current year's fiscal budget was adequate.

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[3] During interviews, medical facility leaders discussed the progress made to address the top five facility-reported clinical and nonclinical occupational shortages during FY 2020, whether those shortages continued in FY 2021, and the interim strategies to alleviate the service- or section-level stresses. Leaders described the use of telehealth, community care, and recruitment and retention bonuses as common strategies to address current shortages.

To assess employee attitudes toward medical facility leaders during FY 2021 inspections, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from FY 2020 and assessed the extent to which the inspected facilities improved their performance for the three selected survey questions from FY 2020 to 2021. The comparison demonstrated that the majority of inspected facilities improved their performance from FY 2020 to 2021. The OIG performed the same analysis for selected patient survey results for FYs 2020 and 2021. The comparison demonstrated that while more inspected facilities had improved inpatient satisfaction survey scores, most inspected facilities' outpatient primary and specialty care scores had worsened in FY 2021.

The OIG noted the facilities' inspections by the College of American Pathologists, Commission on Accreditation of Rehabilitation Facilities, Long Term Care Institute, and Paralyzed Veterans of America. The facility leaders appeared actively engaged in addressing open recommendations from previous OIG inspections and The Joint Commission surveys.

[3] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

The OIG also reviewed the number of facility-reported sentinel events, institutional disclosures, and large-scale disclosures since the facilities' previous OIG cyclical review.[4] The OIG observed that most sentinel events and disclosures occurred at highly complex facilities.

The Reporting, Analytics, Performance, Improvement and Deployment of the Office of Organizational Excellence developed the Strategic Analytics for Improvement and Learning Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[5] Leaders were generally able to discuss the causes of facility-specific and poorly performing metrics, as well as actions taken or currently underway to improve performance. However, only 12 facilities (27 percent) had overall improvement in the performance of main measures for the fourth quarter of FY 2021 compared to the prior year.

Conclusion

The OIG conducted detailed inspections at 45 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.

VA Comments

The Under Secretary for Health concurred with the report without comment (see appendix C, page 37, for the executive's response).

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

[4] A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue." VHA Directive 1004.08.

[5] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center (VSSC).

Contents

Abbreviations ii

Report Overview iii

Inspection Results iii

Purpose and Scope 1

Methodology 3

Results 4

Executive Leadership Position Stability and Engagement 4

Budget and Operations 5

Staffing 6

Employee Satisfaction 6

Patient Experience 15

Accreditation Surveys and Oversight Inspections 23

Identified Factors Related to Possible Lapses in Care and Facility Leaders' Responses 23

Veterans Health Administration Performance Data 24

Leadership and Organizational Risks Conclusion 27

Appendix A: Parent Facilities Inspected 29

Appendix B: Summary Results 31

Appendix C: Under Secretary for Health Comments 37

OIG Contact and Staff Acknowledgments 38

Report Distribution 39

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 evaluates specific areas of focus on a rotating basis each year, this evaluation 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 staff'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
- Budget and operations
- Staffing
- Employee satisfaction
- Patient experience
- 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 45 VHA medical facilities from November 30, 2020, through August 23, 2021. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a

[1] Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. No. 111-163, § 505 (2010).

[2] Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement White Paper, 2006.

[3] In VA, a nursing home is referred to as a community living center.

snapshot of VHA leaders' performance at the time of the fiscal year (FY) 2021 OIG inspections and should be considered when improving operations and healthcare quality and mitigating organizational risks.[4]

[4] FY 2021 began October 1, 2020, and ended September 30, 2021.

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 45 facilities inspected represented a mix of size, affiliation, and geographic location. The OIG published individual CHIP reports for each facility. For this report, the OIG aggregated and analyzed data from the individual facility inspections 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 inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[5] The 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

Executive Leadership Position Stability and Engagement

The OIG performed this review at facilities associated with six Veterans Integrated Service Networks (VISNs) and representing 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 (20 of 45 facilities) included a facility director, chief of staff, associate director for patient care services (ADPCS), and associate director (primarily nonclinical). The next most common team composition (14 of 45 facilities) included those leaders previously mentioned and an assistant director (see appendix B, table B.3). The chiefs of staff and ADPCSs oversaw patient care, which required managing service directors and program chiefs.

During each comprehensive healthcare inspection, the OIG collected human resources data pertaining to the leadership team, which indicated whether the positions were permanently occupied and each leader's tenure. For the 212 leadership positions reviewed, 182 positions (86 percent) were filled by permanent leaders, while leaders in 30 positions (14 percent) served in an interim capacity (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. The 42 permanently assigned facility directors had served in their positions for an average of approximately 3 years; tenure ranged from 10 weeks to 11 years. The OIG also noted that 42 chiefs of staff had served in their roles an average of 3 years. The newest chief of staff had been in the role for just over 3 weeks, and the most experienced had served for over 17 years.

The OIG found a range of tenures for the permanently assigned ADPCSs, associate directors, and assistant directors. The 40 ADPCSs appeared to be the most stable among this group, having served in their roles an average of almost 6 years. The newest ADPCS was on the job for approximately 8 months, and the most experienced had served for over 32 years. The OIG also found that the 37 associate directors and 15 assistant directors had served in their positions an average of about 3 and 2 years, respectively. The associate directors' tenures ranged from approximately 2 weeks to over 7 years, and the assistant directors' tenures ranged from approximately 6 weeks to 8 years (see appendix B, table B.5). However, while conducting

[7] VA administers healthcare services through a nationwide network of 18 regional offices referred to as Veterans Integrated Service Networks. "[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." "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES).

FY 2021 comprehensive healthcare inspections, the OIG found that over 40 percent of the permanently assigned VA medical facility leaders had an overall tenure of 2 years or less (see appendix B, table B.6).

During interviews, the OIG assessed facility directors' participation and engagement with quality, safety, and value activities and whether they felt supported by VISN leaders. Facility directors described spending notable time supporting quality, safety, and value and improvement activities. When asked about the level of VISN support for quality improvement activities, 42 of the 45 facility directors indicated that VISN leaders provided adequate support.

VA is implementing a new electronic health record system as part of its effort to modernize operations. The Electronic Health Record Modernization program will transition the storage and tracking of veterans' medical records to this electronic health record system, which has been reported as "one of the most advanced EHRs [electronic health records] in the country."[8] During the transition, the new electronic health record system may affect facility staff's ability to provide timely care. Concerns include system instability, use of workarounds, usability issues, 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.

The OIG interviewed facility leaders to gather information on VHA's efforts to mitigate identified risks associated with this implementation. When asked whether communication from the Office of Electronic Health Record Modernization was adequate, 27 percent of facility directors indicated that communication was insufficient. Additionally, the OIG asked facility directors if they had concerns regarding the new electronic health record rollout, and 56 percent expressed some level of concern. This highlights the importance of communication to mitigate potential challenges related to the electronic health record system transition.

Budget and Operations

During each comprehensive healthcare inspection, the OIG reviewed the medical facility's FY 2020 annual medical care budget, compared it to the previous year's budget, and asked the facility director about the effect of this change on operations and whether the current year's budget (FY 2021) was adequate. Only the VA New York Harbor Healthcare System (HCS) experienced a decrease in its medical care budget from FY 2019 to FY 2020. When asked about the effect of this change on the healthcare system's operations, the Director reported that the budget was adequate because additional COVID-19 funds that were not reflected in the budget were allocated and used to hire permanent outpatient staff. Additionally, 78 percent of facility

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

directors, including the VA New York Harbor HCS Director, indicated that the current fiscal year's budget was adequate.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[9] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[10]

During interviews, medical facility leaders discussed the progress made to address the top five facility-reported clinical and nonclinical occupational shortages during FY 2020, whether those occupations continued to be the top five shortages in FY 2021, and the interim strategies implemented to alleviate the service- or section-level stresses caused by the current shortages. Leaders described common strategies as the use of telehealth, community care, and incentives such as recruitment and retention bonuses.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] The instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[12] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee attitudes toward medical facility leaders during FY 2021 inspections, the OIG reviewed employee satisfaction survey results from VHA's FY 2020 All Employee Survey (October 1, 2019, through September 30, 2020). Figures 2–4 illustrate the inspected facilities' overall performance relative to each other and VHA.[13] Regarding senior leaders generating high levels of motivation and commitment in the workforce, 17 of the 45 facilities inspected during FY 2021 scored better than the VHA average (3.44). The highest score was observed for the

[9] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

[10] VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46 (2017); VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*, Report No. 20-01249-259, September 23, 2020.

[11] "AES Survey History, Understanding Workplace Experiences in VA," VA Support Service Center (VSSC).

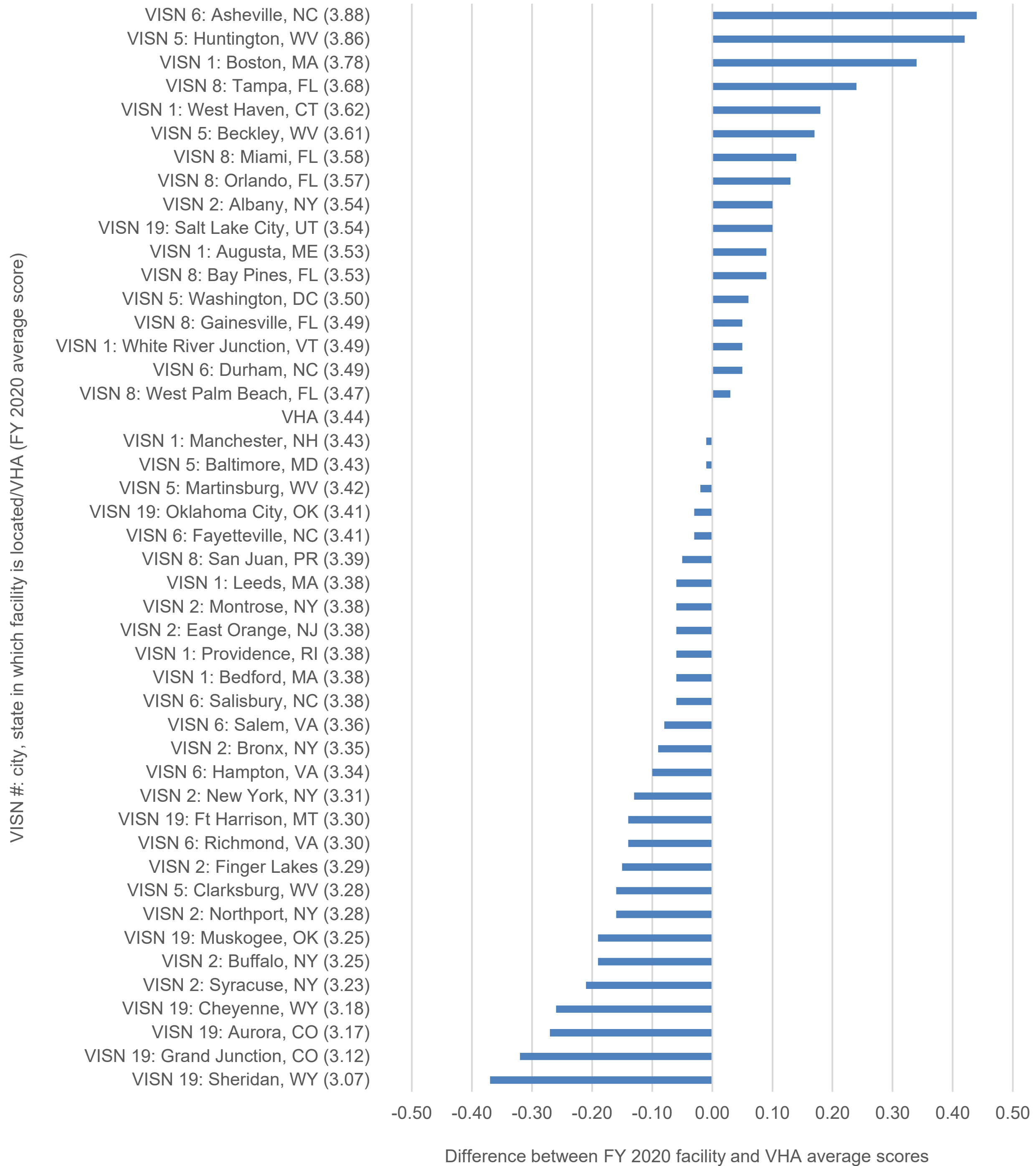
[12] "AES Survey History," VSSC website.

[13] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

Charles George VA Medical Center (VAMC) in Asheville, North Carolina (3.88). The lowest performer was the Sheridan VAMC in Wyoming (3.07) (see figure 2).

Similar results were observed when facility employees shared their feelings about senior leaders maintaining high standards of honesty and integrity and if they had a high level of respect for those leaders. Twenty of the 45 facilities inspected during FY 2021 scored better than the VHA average for both questions. Again, the highest scores were observed for the Charles George VAMC, and the lowest for the Sheridan VAMC (see figures 3 and 4).

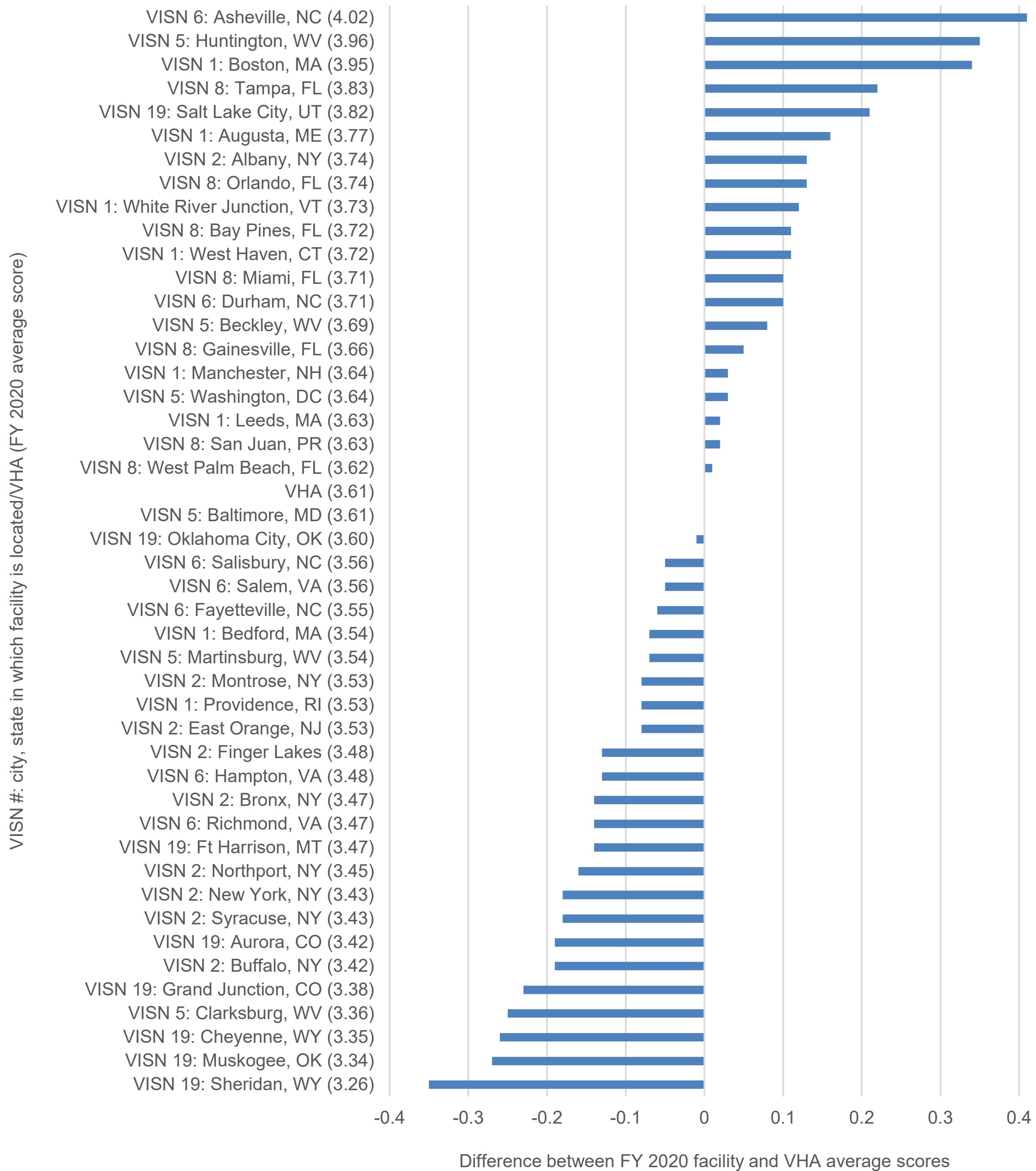
Figure 2. All Employee Survey Results: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce. (FY 2020)**



Source: VA All Employee Survey (accessed February 17, 2022).

**This question is scored on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree) or 6 (Not applicable or Do not know). The chart above only includes scores 1 through 5.*

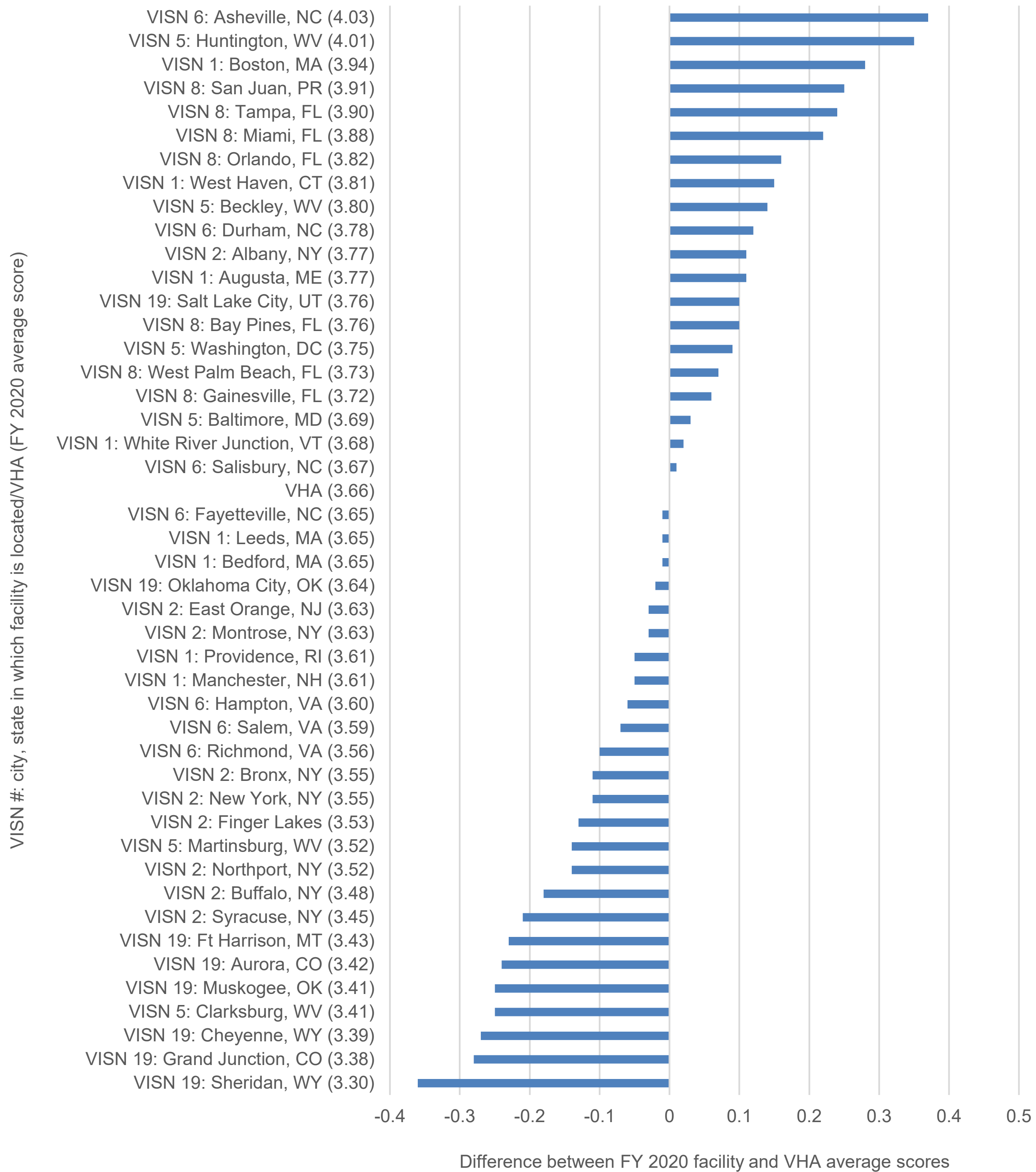
Figure 3. All Employee Survey Results: *My organization's senior leaders maintain high standards of honesty and integrity.**
(FY 2020)



Source: VA All Employee Survey (accessed February 17, 2022).

**This question is scored on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree) or 6 (Not applicable or Do not know). The chart above only includes scores 1 through 5.*

Figure 4. All Employee Survey Results: *I have a high level of respect for my organization's senior leaders.** **(FY 2020)**



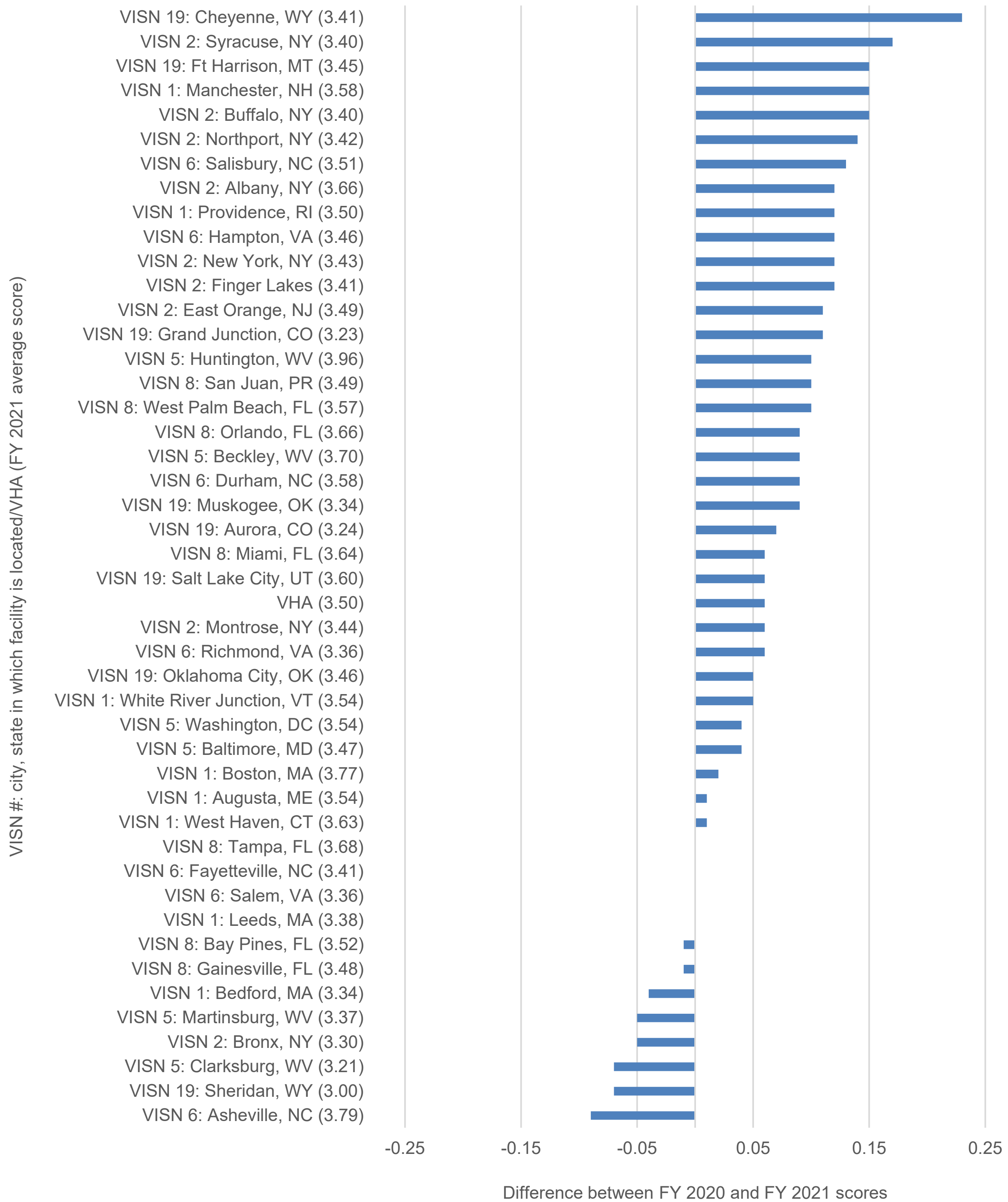
Source: VA All Employee Survey (accessed February 17, 2022).

**This question is scored on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree) or 6 (Not applicable or Do not know). The chart above only includes scores 1 through 5.*

As part of the post-inspection process, the OIG also assessed the extent to which the inspected facilities improved their performance for the three selected All Employee Survey questions from FY 2020 to 2021. Figures 5–7 illustrate changes in scores from one year to the next for each facility and for VHA, with improvements noted by a positive value. For example, the Cheyenne VAMC had the most improved score from FY 2020 to 2021 for the question regarding senior leaders generating high levels of motivation and commitment in the workforce—the FY 2020 score of 3.18 (see figure 2) improved to 3.41 (see figure 5). Further, although the Charles George VAMC was the highest performer among the inspected facilities for this question in FY 2020, the facility had the greatest decrease in its score from FY 2020 to 2021 (3.88 to 3.79; see figures 2 and 5).

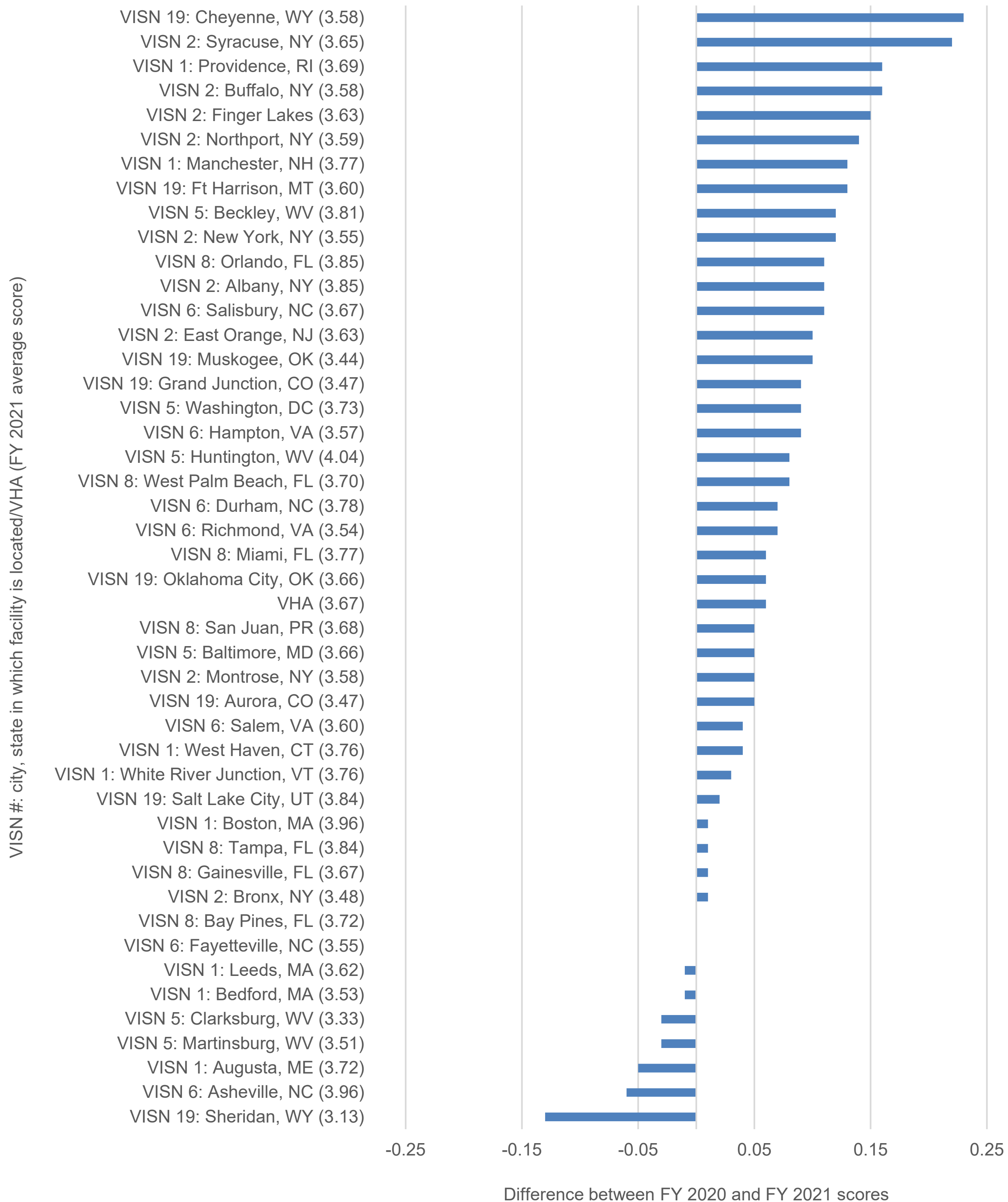
The OIG noted that the Sheridan VAMC was the lowest performer among the inspected facilities for the selected All Employee Survey questions for FY 2020 and remained one of the lowest performers for the same questions the following year (see figures 5–7). However, the OIG also observed that most inspected facilities improved their performance for the three selected questions from FY 2020 to 2021.

Figure 5. All Employee Survey Results: ***In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*** **(Change from FY 2020 to 2021)**



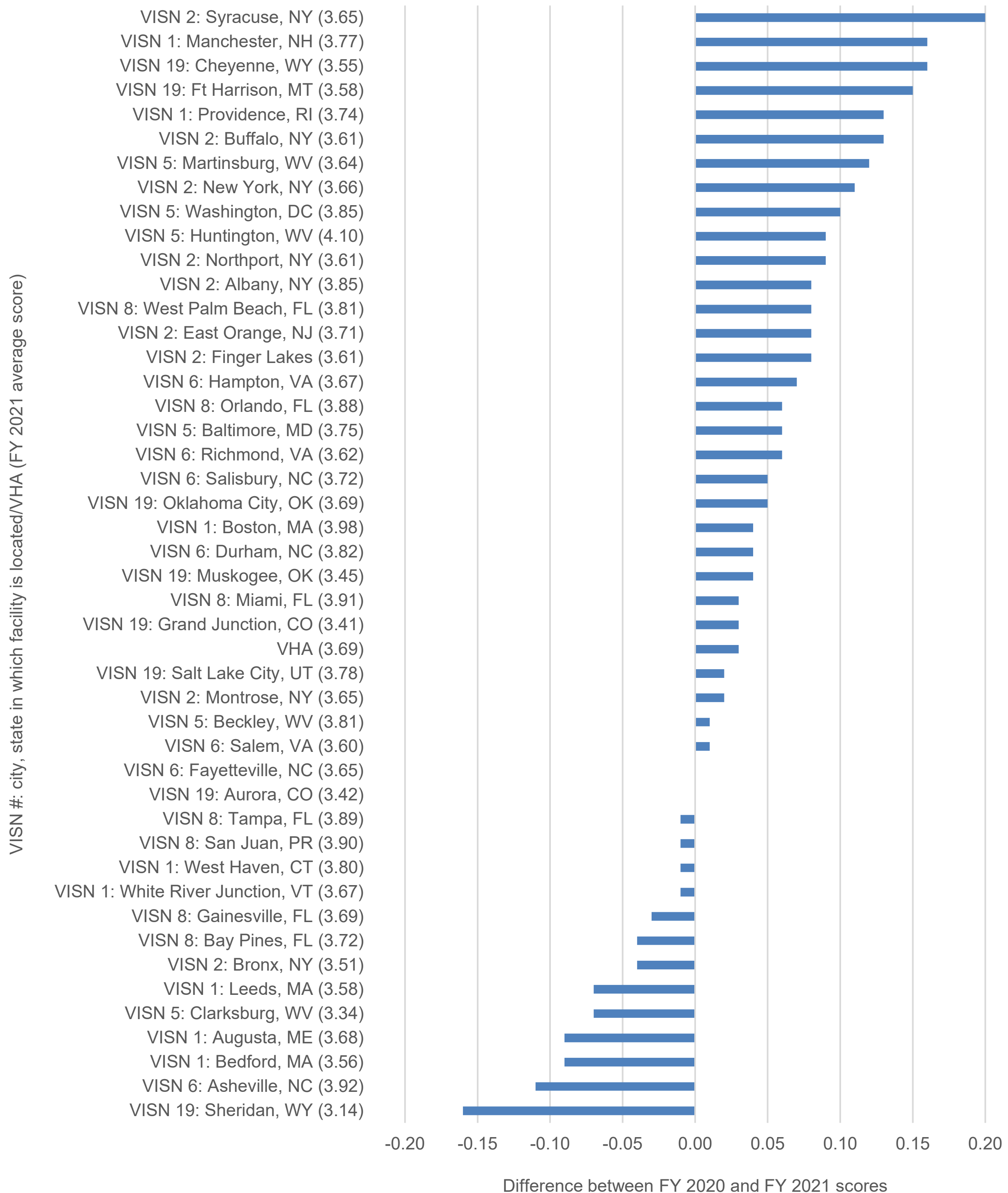
Source: VA All Employee Survey (accessed February 17, 2022).

Figure 6. All Employee Survey Results: ***My organization's senior leaders maintain high standards of honesty and integrity.***
(Change from FY 2020 to 2021)



Source: VA All Employee Survey (accessed February 17, 2022).

Figure 7. All Employee Survey Results: ***I have a high level of respect for my organization's senior leaders.*** **(Change from FY 2020 to 2021)**



Source: VA All Employee Survey (accessed February 17, 2022).

Patient Experience

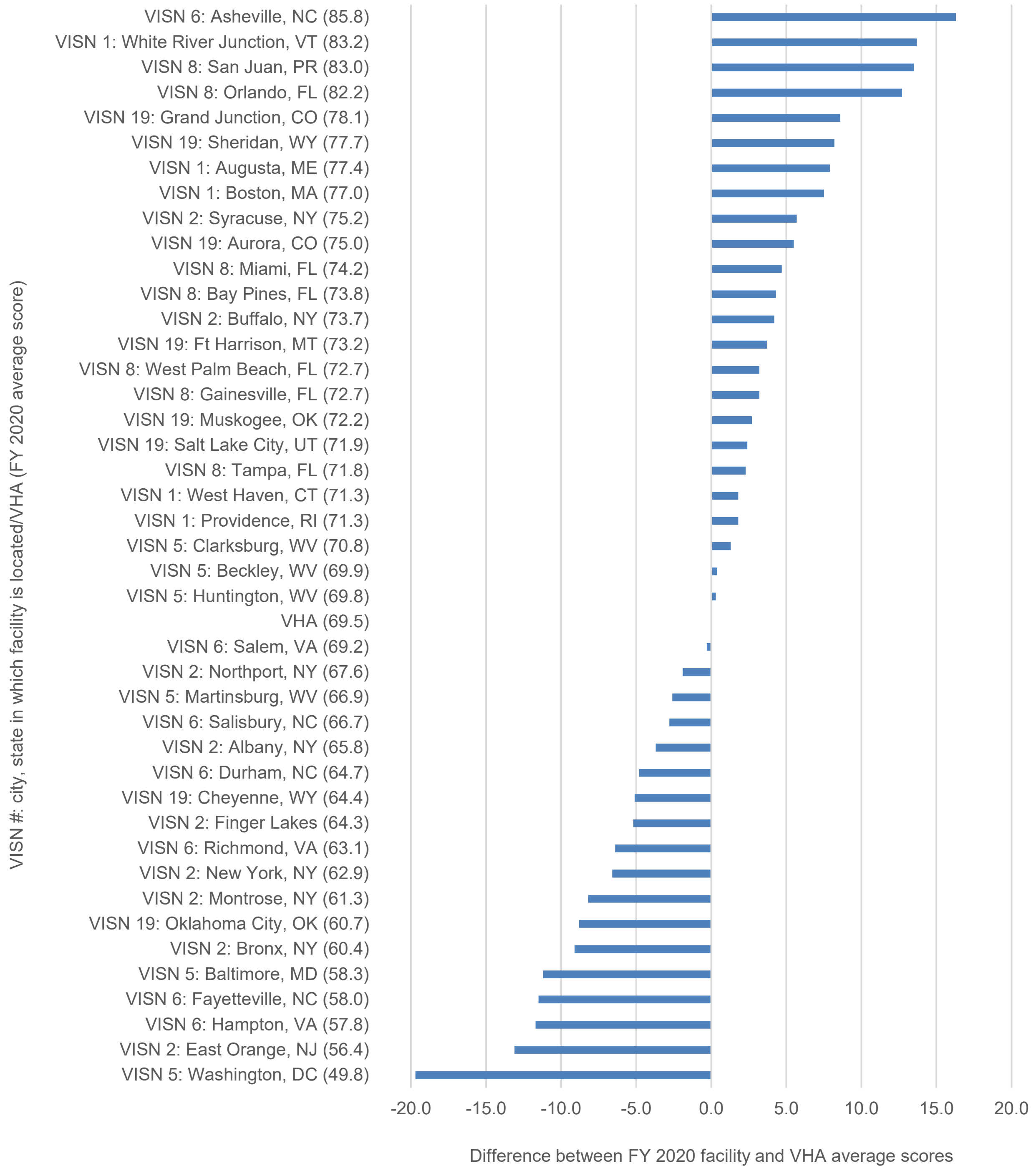
To assess patient experiences with medical facilities, which directly reflect on leaders, the OIG team reviewed Survey of Healthcare Experiences of Patients results for FY 2020. VHA collects survey data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Figures 8–10 illustrate the inspected facilities' overall performance relative to each other and VHA.[14]

Regarding inpatients' willingness to recommend the facility to friends and family, 24 of 42 facilities scored better than the VHA average (69.5).[15] The highest score was observed for the Charles George VAMC (85.8). The lowest performer was the Washington DC VAMC (49.8) (see figure 8). Figure 9 presents the range of inspected facility performance for the selected outpatient patient-centered medical home (primary care) question assessing satisfaction with health care received during the last six months. The highest score was observed for the VA Connecticut HCS in West Haven (89.7). The Hampton VAMC in Virginia received the lowest score (73.6). The highest outpatient specialty care satisfaction score among the inspected facilities was at the VA Boston HCS in Jamaica Plain, Massachusetts (93.0). The lowest performer was the Hampton VAMC (76.4) (see figure 10).

[14] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

[15] VISN 1's Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts; Manchester VAMC in New Hampshire; and VA Central Western Massachusetts HCS in Leeds did not provide inpatient care and are not represented in figure 8.

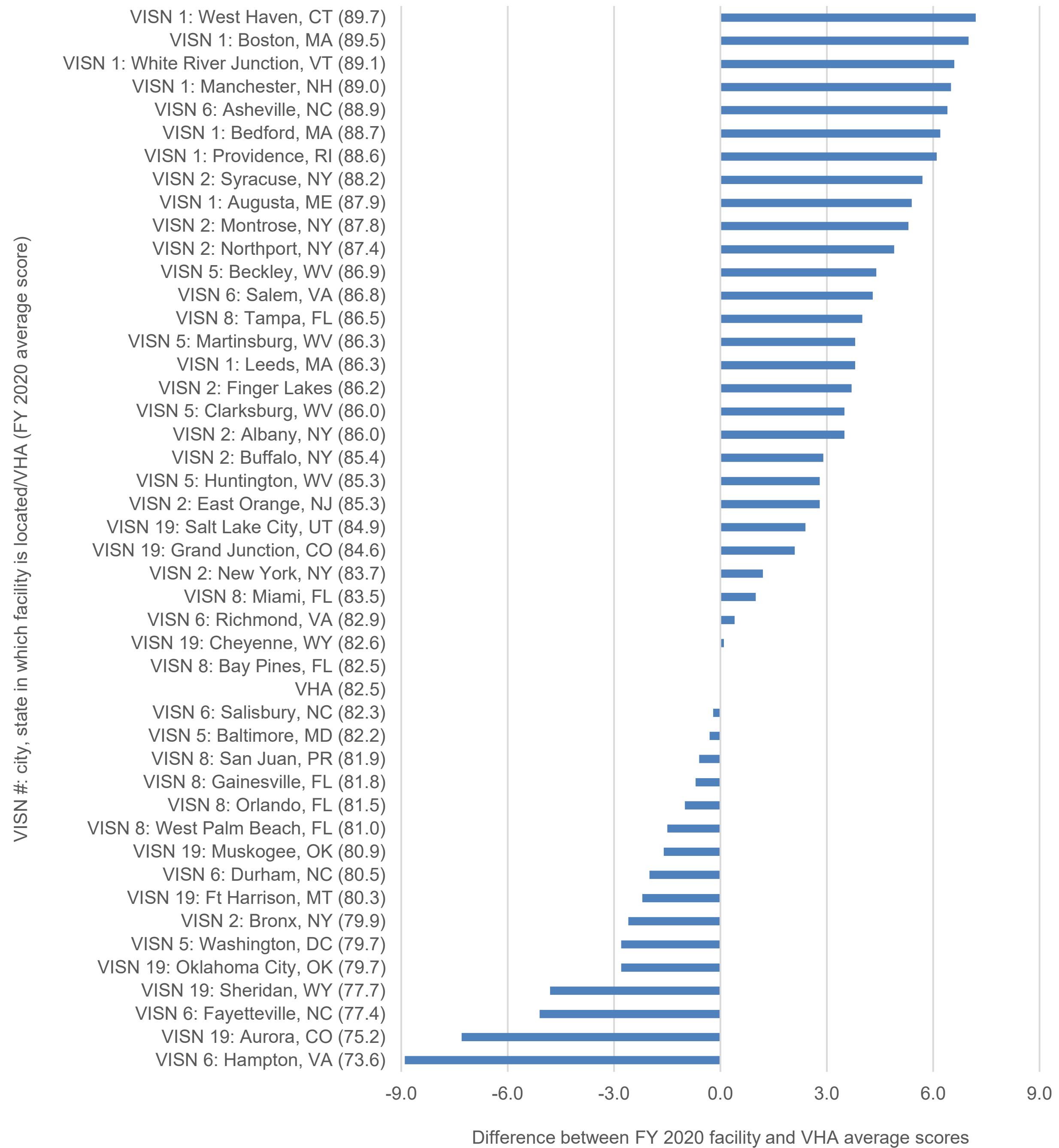
Figure 8. Survey of Healthcare Experiences of Patients (Inpatient): *Would you recommend this hospital to your friends and family?**
(FY 2020)



Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed February 17, 2022).

**The response average is the percent of "Definitely Yes" responses.*

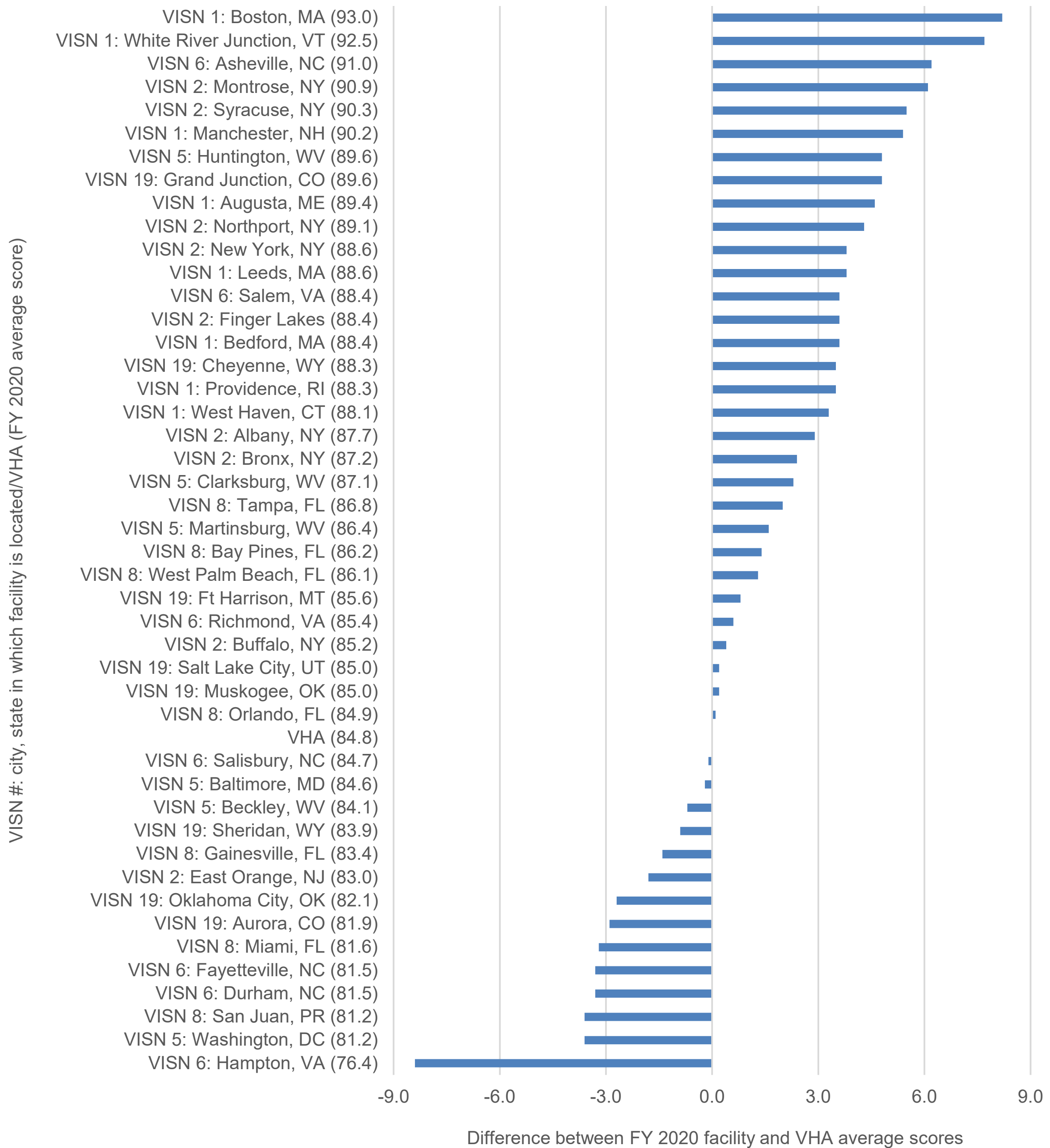
Figure 9. Survey of Healthcare Experiences of Patients (Outpatient Patient-Centered Medical Home (primary care)): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months? (FY 2020)**



Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed February 17, 2022).

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

Figure 10. Survey of Healthcare Experiences of Patients (Outpatient Specialty Care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months? (FY 2020)**



Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed February 17, 2022).

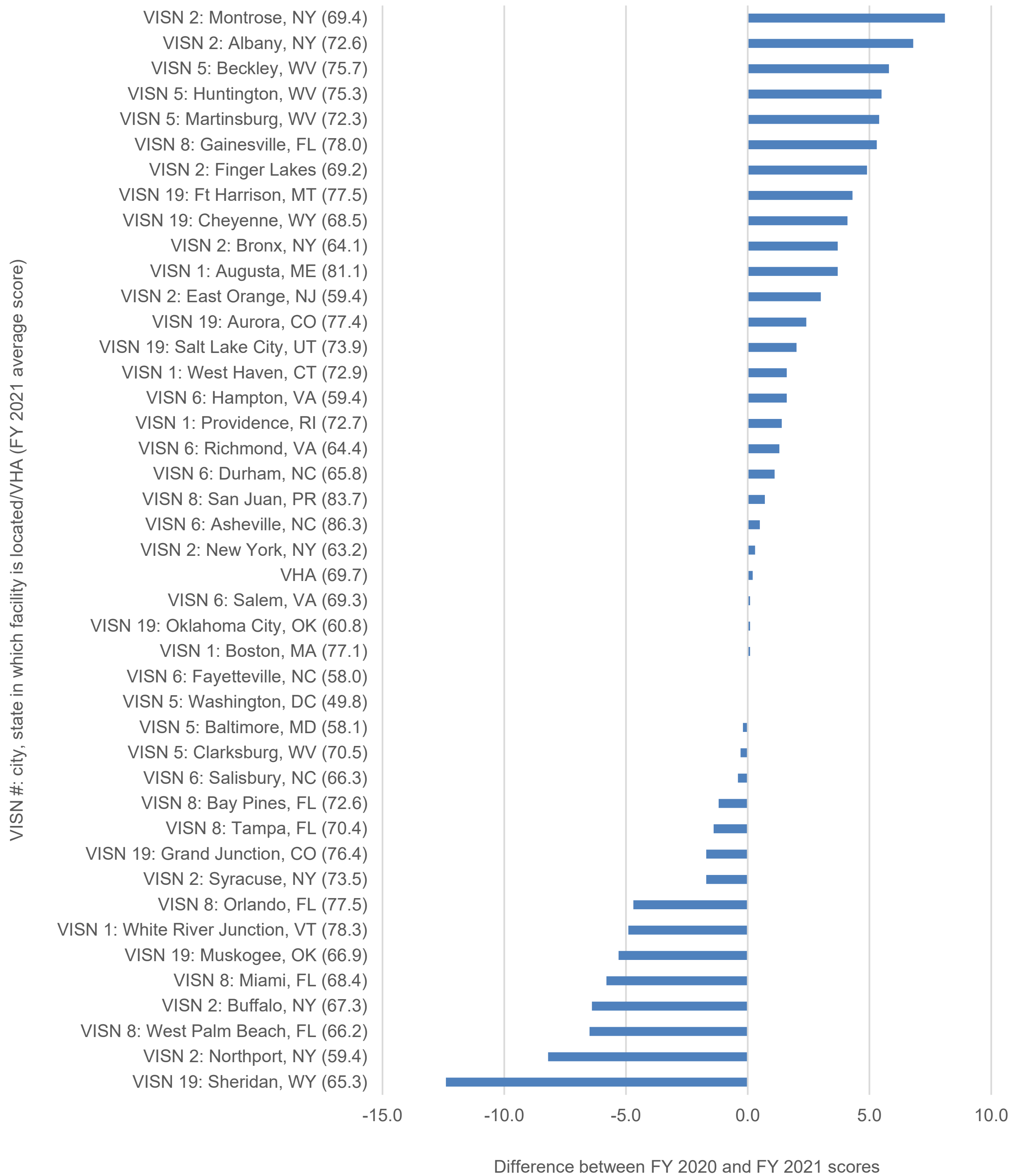
**The response average is the percent of "Very satisfied" and "Satisfied" responses.*

The OIG also assessed the extent to which the inspected facilities improved their performance for the three selected Survey of Healthcare Experiences of Patients questions from FY 2020 to 2021. Figures 11–13 illustrate changes in scores from one year to the next for each facility and for VHA, with improvements noted by a positive value. For example, the VA Hudson Valley HCS in Montrose, New York had the most improved score from FY 2020 to 2021 for the question regarding inpatients' willingness to recommend the hospital to friends and family—the FY 2020 score of 61.3 (see figure 8) improved to 69.4 (see figure 11). The Sheridan VAMC's score had decreased the most from FY 2020 to 2021 (77.7 to 65.3) (see figures 8 and 11).

Figure 12 presents the change in facility scores from FY 2020 to 2021 for the selected outpatient patient-centered medical home (primary care) question assessing satisfaction with health care received during the last six months. The greatest improvement was observed for the Hunter Holmes McGuire VAMC in Richmond, Virginia (82.9 in FY 2020 to 88.9 in FY 2021). The biggest decrease in performance was observed at the Fayetteville VA Coastal HCS in North Carolina (77.4 in FY 2020 to 69.7 in FY 2021) (see figures 9 and 12).

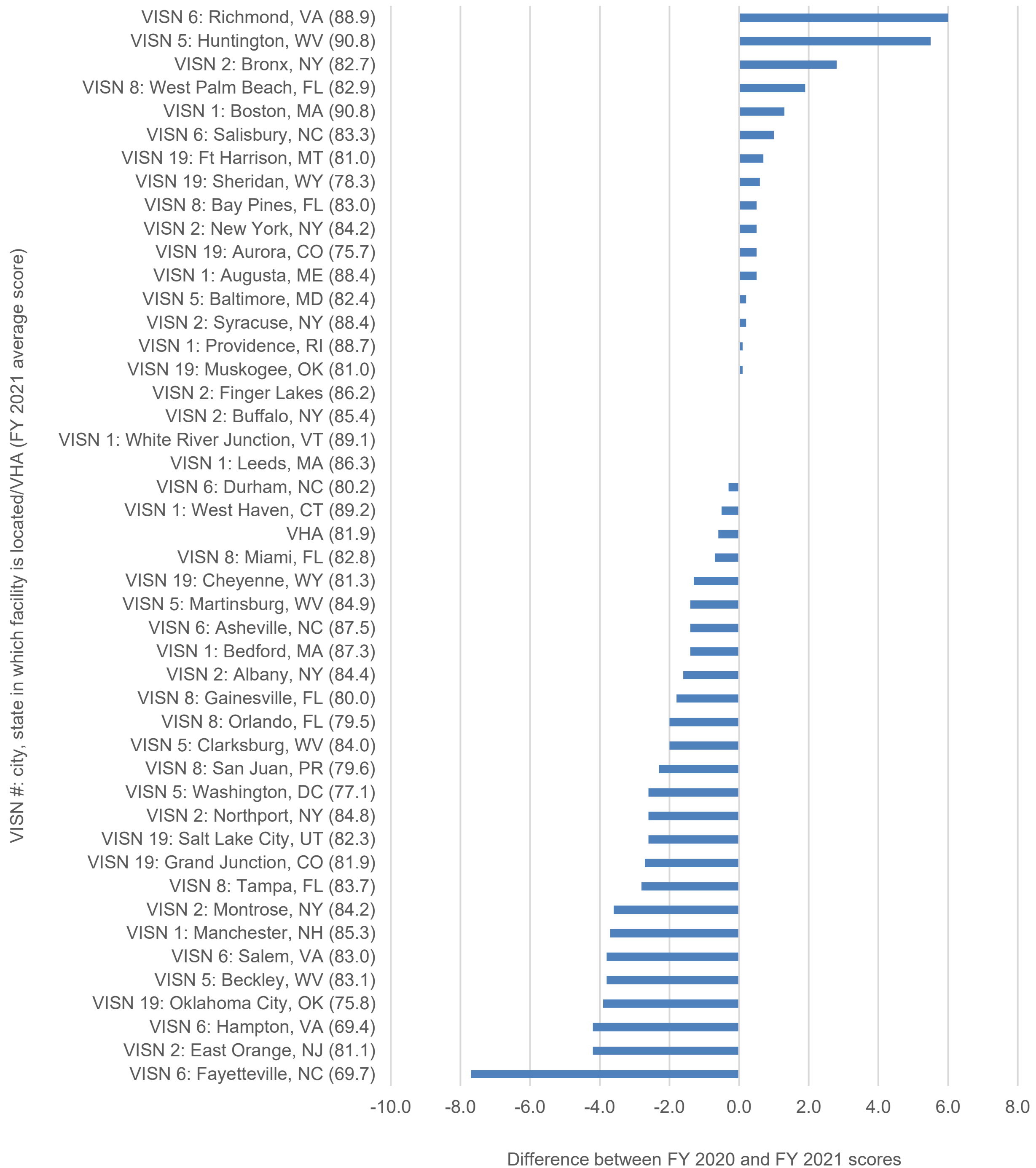
The most improved of the inspected facilities for outpatient specialty care satisfaction was the VA New Jersey HCS in East Orange (83.0 in FY 2020 to 85.1 in FY 2021). The greatest decrease in performance was observed at the VA Caribbean HCS in San Juan, Puerto Rico (81.2 in FY 2020 to 69.1 in FY 2021) (see figures 10 and 13). Further, the comparison demonstrated that the majority of inspected facilities' scores had worsened in FY 2021 (see figure 13).

Figure 11. Survey of Healthcare Experiences of Patients (Inpatient): *Would you recommend this hospital to your friends and family?* (Change from FY 2020 to 2021)



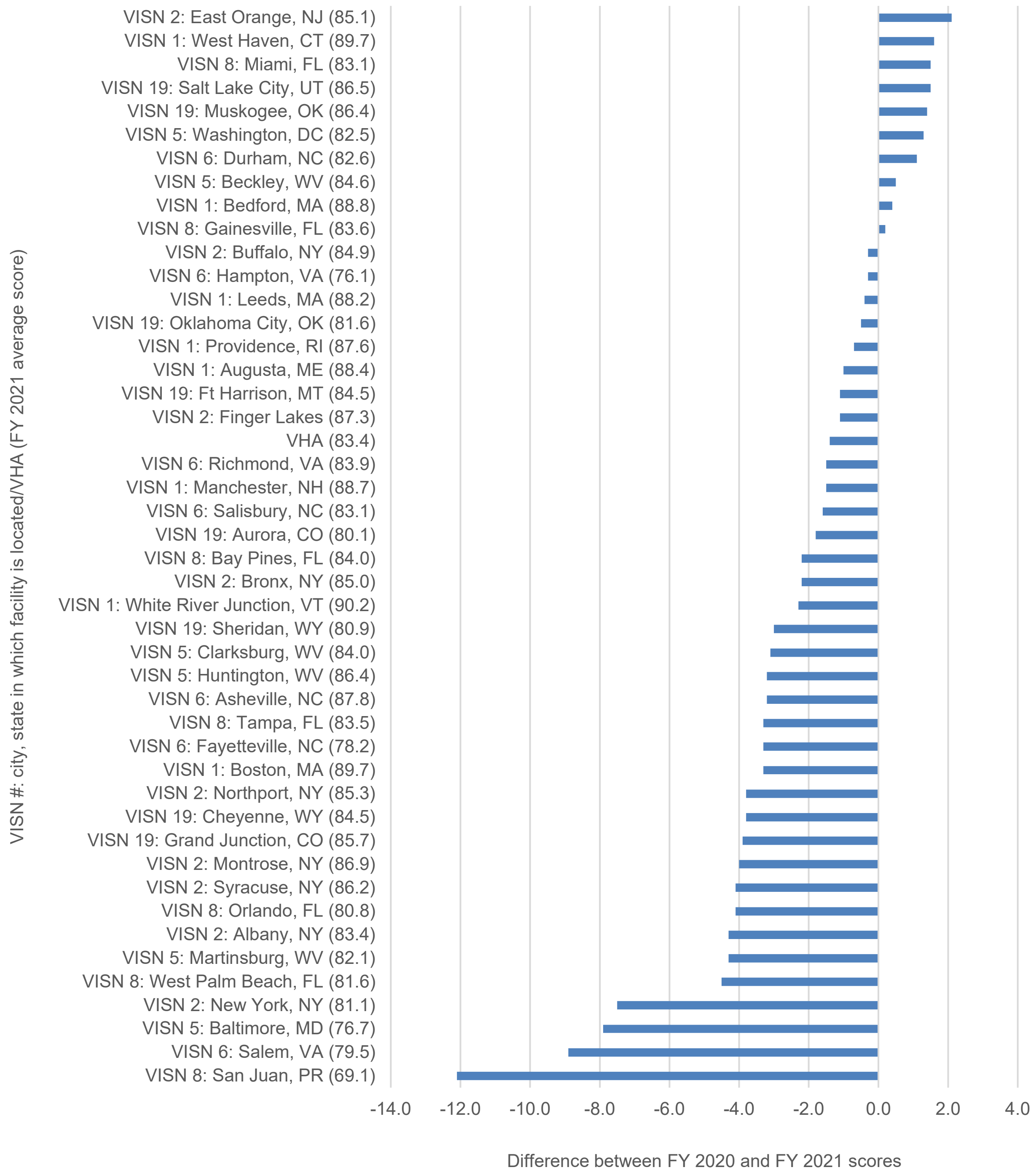
Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed February 17, 2022).

Figure 12. Survey of Healthcare Experiences of Patients (Outpatient Patient-Centered Medical Home (primary care)): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?* (Change from FY 2020 to 2021)



Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed February 17, 2022).

Figure 13. Survey of Healthcare Experiences of Patients (Outpatient Specialty Care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?* (Change from FY 2020 to 2021)



Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed February 17, 2022).

Accreditation Surveys and Oversight Inspections

The OIG noted that 33 facilities (73 percent) had received College of American Pathologists inspections since the previous OIG cyclical review.[16] Forty facilities (89 percent) had received accreditation from the Commission on Accreditation of Rehabilitation Facilities for at least one rehabilitation program.[17] Additionally, 38 facilities (84 percent) underwent Long Term Care Institute inspections, and 11 (24 percent) were surveyed by the Paralyzed Veterans of America.[18] The facility leaders appeared actively engaged in addressing open recommendations from previous OIG inspections and The Joint Commission surveys. The OIG also found that since each facility's previous OIG cyclical review, The Joint Commission had performed routine unannounced surveys at 41 facilities and for-cause surveys at 6 facilities.

At the time of the inspections, 9 facilities had open recommendations from the previous OIG CHIP visit. From the time of the previous OIG inspections to the FY 2021 reviews, the 45 facilities underwent 42 OIG hotline inspections that resulted in 228 recommendations. For 65 recommendations that remained open at the time of the CHIP visits, the OIG found that insufficient time had passed to initiate follow-up, or that facility leaders were still actively engaged in addressing the recommendations or still monitoring for sustained improvement.

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.

---

[16] 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." "About the College of American Pathologists," College of American Pathologists, accessed May 31, 2022, https://www.cap.org/about-the-cap.

[17] 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." VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017.

[18] 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." "About Us," Long Term Care Institute, accessed May 21, 2022, http://www.ltciorg.org/about-us/. This veterans service organization review does not result in accreditation status. Facilities with a spinal cord injury and disease center are eligible for Paralyzed Veterans of America inspection. Paralyzed Veterans of America, accessed July 21, 2022, https://pva.org/.

Culture affects the reporting of patient safety events within an organization. If the organization has a culture of safety, staff feel safe reporting adverse events, whereas staff may not disclose events when they perceive that doing so puts them at risk for disciplinary or retaliatory actions. Therefore, low numbers do not necessarily mean that staff provide good care, and high numbers do not mean that they provide poor care.

The OIG reviewed the number of facility-reported sentinel events, institutional disclosures, and large-scale disclosures since each facilities' previous OIG cyclical review.[19] Forty-three facilities reported a total of 382 sentinel events, ranging from 1 to 42 (two facilities reported none), with complexity 1b facilities recording the highest average (see appendix B, tables B.7 and B.9). Forty-four facilities reported a total of 535 institutional disclosures ranging from 1 to 53 (one facility reported none), again with the highest average occurring at complexity 1b facilities (see appendix B, tables B.8 and B.10).[20] Additionally, one facility reported conducting two large-scale disclosures.[21]

Veterans Health Administration Performance Data

The Reporting, Analytics, Performance, Improvement and Deployment of the Office of Organizational Excellence developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with main "measures on healthcare quality, employee satisfaction, [and] access to care."[22] The OIG assessed the leaders' level of engagement with improvement activities involving SAIL data.[23] When asked about facility-specific, poorly performing metrics, leaders were generally able to discuss their

---

[19] A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue." VHA Directive 1004.08.

[20] VHA defines complexity 1b facilities as those with "medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs." "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES).

[21] The large-scale disclosures involved the use of incorrect needles for influenza vaccinations and inappropriate phlebotomies (drawing blood from a vein) as part of patient care.

[22] "SAIL Value Model," VSSC website.

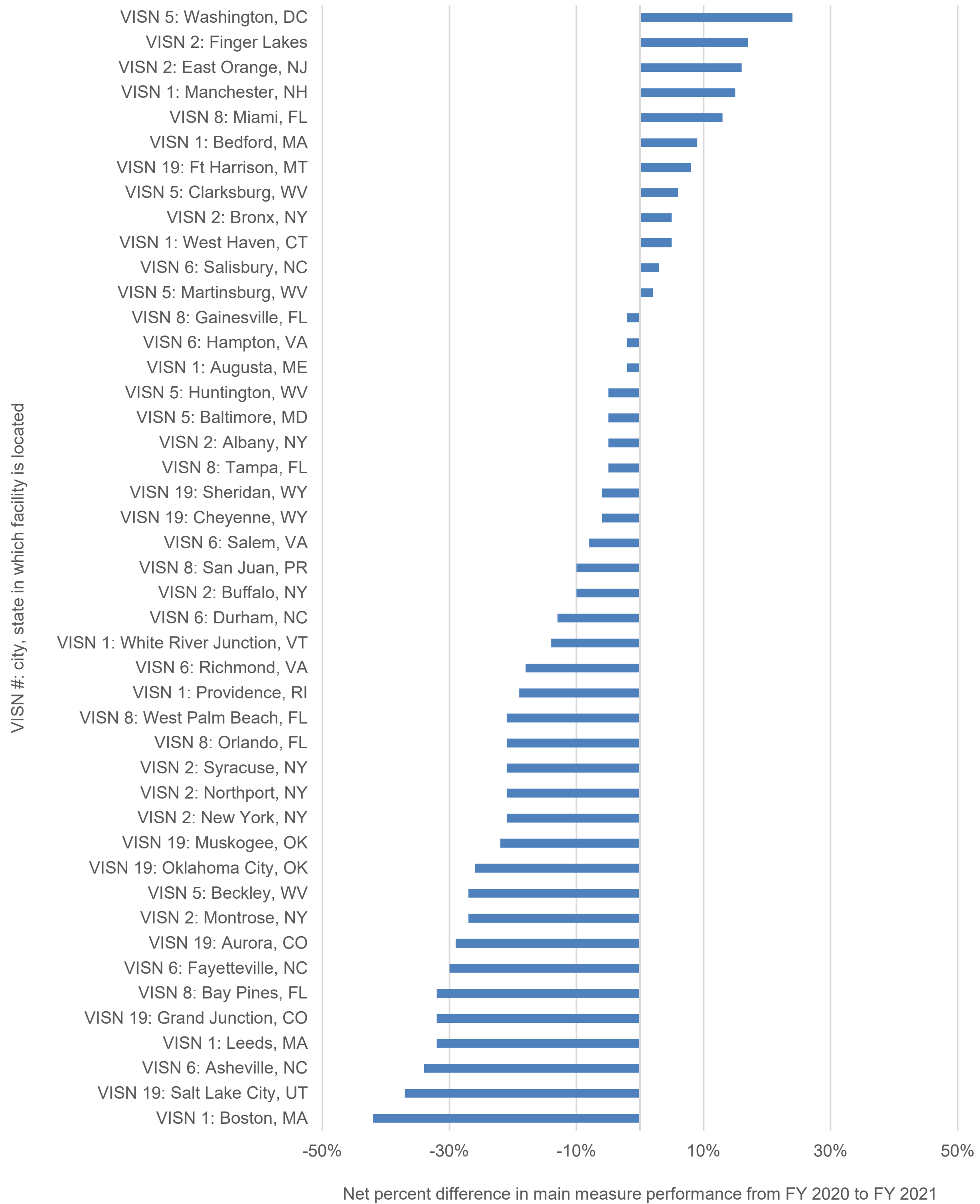
[23] The OIG assessed facility leaders' responses to specific questions using a scale of 1–5, where a score of 1 indicated the interviewee had no answer or could not provide a substantive response, and a 5 indicated the interviewee provided a thorough response that included in-depth understanding of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

causes as well as actions taken or currently underway to improve performance.[24] However, despite leaders' knowledge of their poorly performing SAIL metrics, only 12 facilities (27 percent) had a net meaningful improvement in the performance of main measures for the fourth quarter of FY 2021 compared to facilities' performance one year prior (see figure 14).[25] The VA Boston HCS had the highest percent of decline in performance for the fourth quarter of FY 2021 (16 percent improved, whereas 58 percent declined, demonstrating an overall decrease in facility performance compared to the previous year). The Washington DC VAMC had the highest percentage of improvement (53 percent improved, while 29 percent declined, demonstrating notable enhanced facility performance over time).

[24] OIG-assigned scores for leaders' responses to questions about factors affecting the two selected SAIL metrics averaged 3.3 for both metrics; responses to questions for actions taken to improve performance for the two metrics were 3.5 and 3.4.

[25] Facility-specific SAIL data includes an analysis and graphical representation of the percent of main measures that have improved or declined from one year ago. Change in performance (improvement or deterioration) is classified as meaningful, small, or trivial. According to VHA's Office of Analytics and Performance, "[t]rivial change is excluded from the percentages." "Center for Strategic Analytics and Reporting," VHA Office of Analytics and Performance Integration (API).

Figure 14. Net Percent of Main Measure Improvement or Decline (Change from FY 2020 to 2021)



Source: VHA's Office of Analytics and Performance (accessed June 8, 2022).

Leadership and Organizational Risks Conclusion

The OIG reviewed leadership and organizational risks at 45 VA facilities inspected between November 30, 2020, and August 23, 2021. Eighty-six percent of leadership positions were filled by permanent staff at the time of their respective inspections. Over half of the leaders interviewed at the facilities had an overall tenure of at least two years. During interviews, facility directors described spending significant time supporting quality, safety, and value and improvement activities. When asked about the level of VISN support for quality improvement activities, 42 of the 45 facility directors indicated that VISN leaders provided adequate support.

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. When asked whether communication from the Office of Electronic Health Record Modernization was adequate, 27 percent of facility directors indicated that communication was insufficient. Additionally, 56 percent of facility directors expressed some level of concern regarding the new electronic health record rollout. This highlights the importance of communication to mitigate potential challenges related to the electronic health record system transition.

During each comprehensive healthcare inspection, the OIG reviewed the medical facilities' FY 2020 annual medical care budget, compared it to the previous year's budget, and asked facility directors about the effect of this change on the facilities' operations and whether the current year's budget (FY 2021) was adequate. VA New York Harbor HCS was the only facility to experience a decrease in its medical care budget from FY 2019 to FY 2020. Additionally, 78 percent of facility directors, including the VA New York Harbor HCS Director, indicated that the current fiscal year's budget was adequate.

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[26] During interviews, medical facility leaders discussed the progress made to address the top five facility-reported clinical and nonclinical occupational shortages during FY 2020, whether those occupations continued to be the top five shortages in FY 2021, and the interim strategies to alleviate the stresses caused by the current shortages. Facility leaders described using strategies such as telehealth, community care, and recruitment and retention bonuses to address occupational shortages.

During FY 2021 inspections, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from FY 2020 to assess employee attitudes toward medical center leaders. Additionally, the OIG compared the FY 2020 scores to those from FY 2021 for three selected survey questions and determined that most inspected facilities had improved their

[26] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

performance. The OIG also performed the same analysis for selected patient survey results for FYs 2020 and 2021. The comparison showed that while more inspected facilities had improved inpatient satisfaction survey scores, a majority of the facilities' outpatient primary and specialty care scores had worsened in FY 2021.

The OIG noted the facilities' inspections by the College of American Pathologists, Commission on Accreditation of Rehabilitation Facilities, Long Term Care Institute, and Paralyzed Veterans of America and facility leaders' active engagement in addressing open recommendations from previous OIG inspections and The Joint Commission surveys. The OIG also reviewed the number of facility-reported sentinel events, institutional disclosures, and large-scale disclosures since the facilities' previous OIG cyclical review and found that most events and disclosures occurred at highly complex facilities.

Additionally, the OIG found that leaders were generally knowledgeable about various performance metrics and could speak to actions taken to improve their respective facility's performance. However, despite leaders' knowledge of their poorly performing SAIL metrics, only 12 facilities (27 percent) had an overall improved performance of main measures for the fourth quarter of FY 2021 compared to facilities' performance one year prior.

Appendix A: Parent Facilities Inspected

Table A.1. Facilities Inspected (October 1, 2020, through September 30, 2021)

Names	City
Bay Pines VA Healthcare System	Bay Pines, FL
Beckley VA Medical Center	Beckley, WV
Charles George VA Medical Center	Asheville, NC
Cheyenne VA Medical Center	Cheyenne, WY
Durham VA Health Care System	Durham, NC
Eastern Oklahoma VA Health Care System	Muskogee, OK
Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA
Fayetteville VA Coastal Health Care System	Fayetteville, NC
Hampton VA Medical Center	Hampton, VA
Hershel "Woody" Williams VA Medical Center	Huntington, WV
Hunter Holmes McGuire VA Medical Center	Richmond, VA
James A. Haley Veterans' Hospital	Tampa, FL
James J. Peters VA Medical Center	Bronx, NY
Louis A. Johnson VA Medical Center	Clarksburg, WV
Manchester VA Medical Center	Manchester, NH
Martinsburg VA Medical Center	Martinsburg, WV
Miami VA Healthcare System	Miami, FL
Montana VA Health Care System	Fort Harrison, MT
North Florida/South Georgia Veterans Health System	Gainesville, FL
Northport VA Medical Center	Northport, NY
Oklahoma City VA Health Care System	Oklahoma City, OK
Orlando VA Healthcare System	Orlando, FL
Providence VA Medical Center	Providence, RI
Salem VA Medical Center	Salem, VA
Samuel S. Stratton VA Medical Center	Albany, NY
Sheridan VA Medical Center	Sheridan, WY
Syracuse VA Medical Center	Syracuse, NY
VA Boston Healthcare System	Jamaica Plain, MA
VA Caribbean Healthcare System	San Juan, PR

Names	City
VA Central Western Massachusetts Healthcare System	Leeds, MA
VA Connecticut Healthcare System	West Haven, CT
VA Eastern Colorado Health Care System	Aurora, CO
VA Finger Lakes Healthcare System	Bath, NY
VA Hudson Valley Health Care System	Montrose, NY
VA Maine Healthcare System	Augusta, ME
VA Maryland Health Care System	Baltimore, MD
VA New Jersey Health Care System	East Orange, NJ
VA New York Harbor Healthcare System	New York, NY
VA Salt Lake City Health Care System	Salt Lake City, UT
VA Western Colorado Health Care System	Grand Junction, CO
VA Western New York Healthcare System	Buffalo, NY
W.G. (Bill) Hefner VA Medical Center	Salisbury, NC
Washington DC VA Medical Center	Washington, DC
West Palm Beach VA Medical Center	West Palm Beach, FL
White River Junction VA Medical Center	White River Junction, VT

Source: VA OIG.

Appendix B: Summary Results

Table B.1. Inspected Facilities by VISN

VISN	Number of Facilities Inspected
VISN 1: VA New England Healthcare System	8
VISN 2: New York/New Jersey VA Health Care Network	9
VISN 5: VA Capitol Health Care Network	6
VISN 6: VA Mid-Atlantic Health Care Network	7
VISN 8: VA Sunshine Healthcare Network	7
VISN 19: VA Rocky Mountain Network	8
Total	**45**

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."	14
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."	13
2–Medium Complexity	"[M]edium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs."	6
3–Low Complexity	"[L]ow volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."	7

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	20
Facility Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director	14
Facility Director, Deputy Director, Chief of Staff, ADPCS	2
Facility Director, Chief of Staff, ADPCS, and two Associate Directors	2
Other	7

Source: VA OIG.

**As of the comprehensive healthcare inspection.*
Other compositions included unique leadership teams generally with the presence or absence of a deputy director and variations in the number of associate and assistant directors.

Table B.4. Facility Leaders Permanently Assigned*

Position	Yes	Yes (%)	No	No (%)	Total
Facility Director	42	93	3	7	45
Chief of Staff	42	93	3	7	45
ADPCS	40	89	5	11	45
Deputy Director	6	67	3	33	9
Associate Director	37	80	9	20	46
Assistant Director	15	68	7	32	22
Overall	**182**	**86**	**30**	**14**	**212**

Source: VA OIG.

**As of the comprehensive healthcare inspection.*
Some inspected facilities did not have an associate director, while other facilities had one or more associate directors.

Table B.5. Average Tenure of Permanent Leaders*

Position	Number of Staff	Average Tenure (Years)	Minimum Tenure Observed (Weeks)	Maximum Tenure Observed (Years)
Director	42	2.8	10.1	11.0
Chief of Staff	42	3.2	3.1	17.7
ADPCS	40	5.7	33.6	32.2
Deputy Director	6	4.4	15.0	9.0
Associate Director	37	2.6	2.1	7.8
Assistant Director	15	2.4	6.1	8.0
Overall	**182**	**3.4**	**2.1**	**32.2**

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	2	2	16	18	4	42
Chief of Staff	3	5	13	11	10	42
ADPCS	0	5	4	15	16	40
Deputy Director	1	0	0	3	2	6
Associate Director	9	5	6	14	3	37
Assistant Director	3	1	2	8	1	15
Overall	**18**	**18**	**41**	**69**	**36**	**182**

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	2	0
1	5	5
2	3	6
3	1	3
4	7	28
5	2	10
6	5	30
8	1	8
9	4	36
10	2	20
11	1	11
12	1	12
15	2	30
16	3	48
17	1	17
18	1	18
19	2	38
20	1	20
42	1	42
Overall	**45**	**382**

Source: VA OIG.

Table B.8. Occurrence of Institutional Disclosures across Facilities

Number of Reported Institutional Disclosures	Number of Facilities	Total Institutional Disclosures
0	1	0
1	3	3
2	3	6
3	5	15
4	2	8
5	6	30
6	1	6
7	1	7
8	1	8
9	3	27
11	3	33
12	1	12
13	3	39
16	1	16
17	1	17
19	1	19
20	1	20
22	1	22
25	1	25
26	1	26
28	2	56
35	1	35
52	1	52
53	1	53
Overall	**45**	**535**

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	140	14	10.0
1b–High Complexity	76	5	15.2
1c–Mid-High Complexity	118	13	9.1
2–Medium Complexity	36	6	6.0
3–Low Complexity	12	7	1.7
Overall	**382**	**45**	**8.5**

Source: VA OIG.

**As of the comprehensive healthcare inspection. Facility complexity levels are defined in Table B.2.*

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	212	14	15.1
1b–High Complexity	80	5	16.0
1c–Mid-High Complexity	201	13	15.5
2–Medium Complexity	26	6	4.3
3–Low Complexity	16	7	2.3
Overall	**535**	**45**	**11.9**

Source: VA OIG.

**As of the comprehensive healthcare inspection. Facility complexity levels are defined in Table B.2.*

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	96	14	6.9
1b–High Complexity	28	5	5.6
1c–Mid-High Complexity	74	13	5.7
2–Medium Complexity	38	6	6.3
3–Low Complexity	42	7	6.0
Overall	**278**	**45**	**6.2**

Source: VA OIG.

**As of the comprehensive healthcare inspection. Facility complexity levels are defined in Table B.2.*

Appendix C: Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: September 20, 2022

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Leadership and Organizational Risks in Veterans Health Administration Facilities, Fiscal Year 2021 2022-00817-HI-1234 (VIEWS # 8351085)

To: Office of 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 Veterans Health Administration Facilities, Fiscal Year 2021, 2022-00817-HI-1234. The Veterans Health Administration (VHA); concurs without comment.

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:)

Shereef Elnahal, M.D., MBA

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Larry Ross, Jr., MS, Project Leader Daisy Arugay, MT Patricia Calvin, MBA, RN Sheila Cooley, MSN, GNP Kimberley De La Cerda, MSN, RN Christine El-Zoghbi, PhD Jennifer Frisch, MSN, RN Miquita Hill-McCree, MSN, RN Carrie Jeffries, DNP, MPH Deborah Naranjo, DNP, RN Rhonda Omslaer, JD, BSN Jennifer Reed, MSHI, RN Simonette Reyes, BSN, RN Cheryl Walsh, MS, RN Elizabeth Whidden, MS, ARNP Michelle Wilt, MBA, BSN
Other Contributors	Limin Clegg, PhD Kaitlyn Delgadillo, BSPH LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Veterans Integrated Service Network Directors (1–23)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

OIG reports are available at www.va.gov/oig.