



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

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare  
Inspection of the Phoenix  
VA Health Care System  
in Arizona



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**Figure 1.** Carl T. Hayden VA Medical Center of the Phoenix VA Health Care System in Arizona.

Source: <https://www.va.gov/phoenix-health-care/>.

## Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Phoenix VA Health Care System, which includes the Carl T. Hayden VA Medical Center and multiple outpatient clinics in Arizona. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

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

The OIG conducted an unannounced inspection of the Phoenix VA Health Care System during the weeks of March 21 and March 28, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

## Inspection Results

The OIG noted opportunities for improvement and issued six recommendations to the Executive Director and Chief of Staff in the following areas of review: Leadership and Organizational Risks; Quality, Safety, and Value; Medical Staff Privileging; and Environment of Care. These results are detailed throughout the report and summarized in appendix A on page 23.

## Conclusion

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

## VA Comments

The interim Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 26–27, and the responses within the body of the report for the full text of the directors’ comments). The OIG considers recommendations 3, 5, and 6 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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# Contents

Abbreviations .....	ii
Report Overview .....	iii
Inspection Results .....	iii
Purpose and Scope .....	1
Methodology .....	2
Results and Recommendations .....	3
Leadership and Organizational Risks.....	3
Recommendation 1 .....	10
Quality, Safety, and Value .....	11
Recommendation 2 .....	12
Recommendation 3 .....	13
Medical Staff Privileging .....	14
Recommendation 4 .....	15
Environment of Care .....	17
Recommendation 5 .....	18
Recommendation 6 .....	19
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives.....	20
Report Conclusion.....	22

Appendix A: Comprehensive Healthcare Inspection Program Recommendations .....23

Appendix B: Healthcare System Profile .....24

Appendix C: VISN Director Comments .....26

Appendix D: Healthcare System Director Comments .....27

OIG Contact and Staff Acknowledgments .....28

Report Distribution .....29



## Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report’s evaluation of the quality of care delivered in the inpatient and outpatient settings of the Phoenix VA Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.<sup>1</sup>

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

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

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

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<sup>1</sup> VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

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

<sup>3</sup> Danae F. Sfantou et al., “Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review,” *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, <https://doi.org/10.3390/healthcare5040073>.

<sup>4</sup> CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years’ focus areas.

## Methodology

The Phoenix VA Health Care System includes the Carl T. Hayden VA Medical Center and associated outpatient clinics in Arizona. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from February 5, 2018, through March 31, 2022, the last day of the unannounced multiday evaluation.<sup>5</sup> During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Executive Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

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<sup>5</sup> The OIG's last comprehensive healthcare inspection of the Phoenix VA Health Care System occurred in February 2018. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in April 2021.

<sup>6</sup> Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

## Results and Recommendations

### Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.<sup>7</sup> High-impact leaders should be person-centered and transparent, engage front-line staff members, have a “relentless focus” on their vision and strategy, and “practice systems thinking and collaboration across boundaries.”<sup>8</sup> When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.<sup>9</sup>

To assess this healthcare system’s leadership and risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders’ responses

### Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team structure consisting of a director, deputy director, operations associate director, resources associate director, associate director for patient care services (ADPCS), and chief of staff. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for more than four months, although the Director had served in the role since June 2020, and the ADPCS for more than one year. The newest member of the team was the Chief of Staff, who had served in an acting capacity from November 2021 until being appointed in February 2022. The resources associate director position was vacant. To help assess the executive leaders’ engagement, the OIG interviewed the Director, Deputy Director, Chief of Staff, ADPCS, and acting Operations

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<sup>7</sup> Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

<sup>8</sup> Swensen, *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

<sup>9</sup> Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care*, Institute for Healthcare Improvement White Paper, 2017.

Associate Director regarding their involvement and support of actions to improve or sustain performance.

## **Budget and Operations**

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of \$1,118,839,616 had increased by almost 17 percent compared to the previous year's budget of \$956,546,052.<sup>10</sup> The Director reported spending funds to purchase equipment and technology as well as hire additional employees. The Deputy Director stated that leaders almost doubled medical, surgical, and intensive care unit personnel to reach normal patient care staffing levels.

## **Employee Satisfaction**

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."<sup>11</sup> 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 healthcare system leaders.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal (see figure 2).<sup>12</sup>

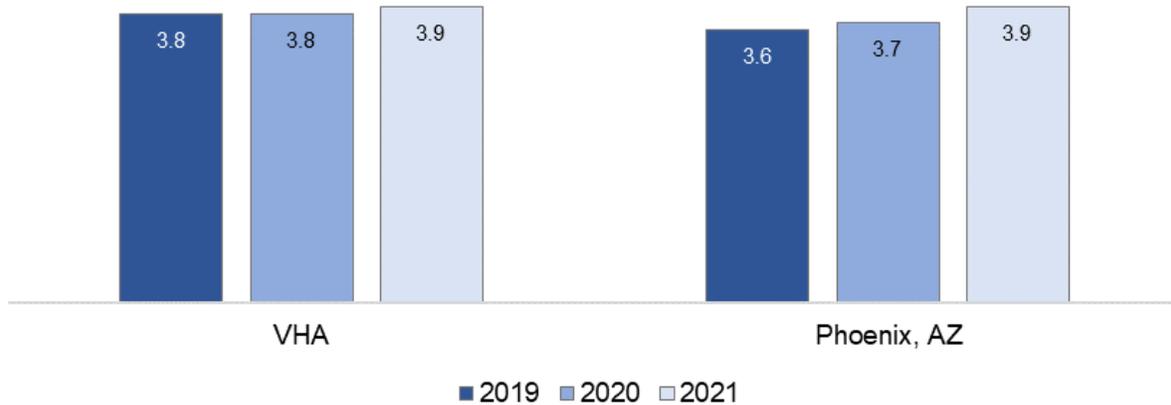
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<sup>10</sup> Veterans Health Administration (VHA) Support Service Center.

<sup>11</sup> "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

<sup>12</sup> The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders' All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variation in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

## Ability to Disclose a Suspected Violation



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

Source: VA All Employee Survey (accessed February 16, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

## Patient Experience

Veterans Health Administration (VHA) uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and benchmark performance against the private sector. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.<sup>13</sup>

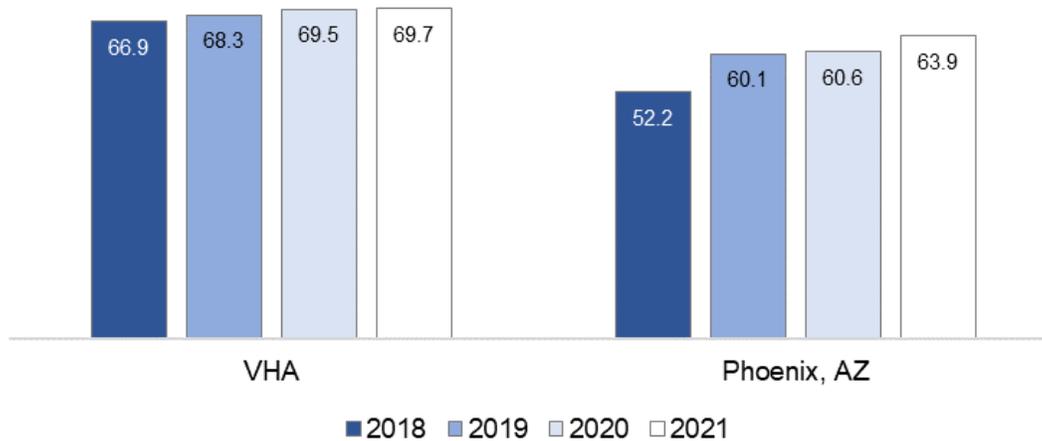
VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.<sup>14</sup> The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2018 through 2021. Figures 3–5 provide survey results for VHA and the healthcare system over time.<sup>15</sup>

<sup>13</sup> “Patient Experiences Survey Results,” VHA Support Service Center.

<sup>14</sup> “Patient Experiences Survey Results,” VHA Support Service Center.

<sup>15</sup> Scores are based on responses by patients who received care at this healthcare system.

### Inpatient Recommendation

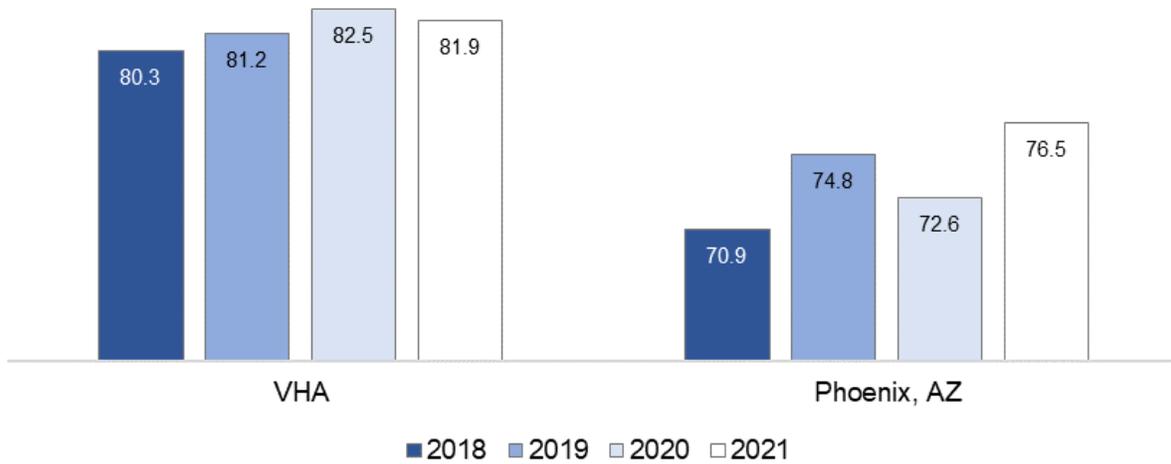


**Figure 3.** Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?

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

Note: The score is the percent of “Definitely yes” responses.

### Outpatient Patient-Centered Medical Home Satisfaction

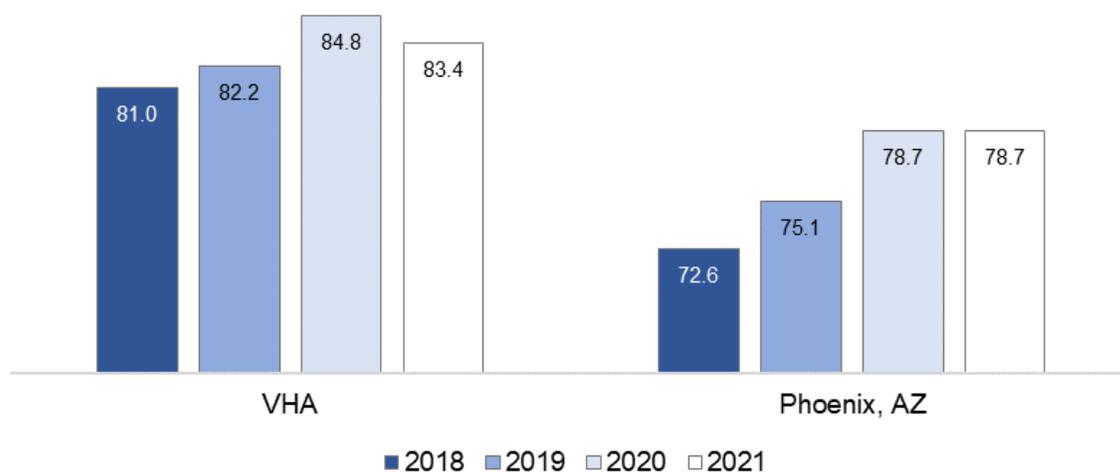


**Figure 4.** Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?

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

Note: The score is the percent of “Very satisfied” and “Satisfied” responses.

### Outpatient Specialty Care Satisfaction



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

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

Note: The score is the percent of “Very satisfied” and “Satisfied” responses.

### Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders’ Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.<sup>16</sup> A sentinel event is an incident or condition that “results in death, permanent harm, or severe temporary harm and [when] intervention [is] required to sustain life.”<sup>17</sup> Additionally, an institutional disclosure is “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s 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.”<sup>18</sup> Lastly, a large-scale disclosure is “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.”<sup>19</sup> To this end, VHA implemented

<sup>16</sup> Frankel, *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

<sup>17</sup> VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

<sup>18</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

<sup>19</sup> VHA Directive 1004.08.

standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.<sup>20</sup> A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.<sup>21</sup>

The Director reported learning of serious adverse patient safety events through the Chief, Quality Safety and Improvement and quality team's recommendations to conduct a root cause analysis; the Chief of Staff; ADPCS; and staff huddles.<sup>22</sup> The Director said that clinical executives and the Quality Safety and Improvement team determined if a disclosure was warranted. The Director also discussed following up with service chiefs if staff did not address patient safety event actions that were documented in the patient safety reporting system.

The Chief of Staff, who was permanently assigned approximately one month before the OIG inspection, stated the quality team informed the leader about two adverse patient safety events that needed institutional disclosures. The Chief of Staff reported completing one disclosure and needing to schedule the other.

The Chief, Quality Safety and Improvement explained that staff can report sentinel events to the Risk Manager or quality team and adverse events through emails, phone calls, and in-person conversations. The Chief, Quality Safety and Improvement added that staff identified sentinel events using a safety grid and Joint Commission guidance.

The Chief, Quality Safety and Improvement stated that if clinicians were involved in events requiring institutional disclosures, staff would notify the quality team, and if the team members were unsure if disclosures were warranted, they would discuss the event with the Chief of Staff. The Chief, Quality Safety and Improvement also said the Chief of Staff made the determination and completed the institutional disclosure.

When asked how sentinel events and institutional disclosures were cross-referenced, the Chief, Quality Safety and Improvement stated that the Patient Safety Manager and the Risk Manager

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<sup>20</sup> The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

<sup>21</sup> Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

<sup>22</sup> A root cause analysis is a focused review to identify the actual system- and process-related contributing factors of the event. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

discussed the events identified as sentinel events and that all discussions were verbal with no documentation.

The OIG noted that the Chief, Quality Safety and Improvement's explanation of the institutional disclosure process differed slightly from the Director's. The Director acknowledged that opportunities existed for leaders to improve their identification of sentinel events. The Director also reported believing there was a broader opportunity for the VISN and VA to agree on a more structured process.

## **Leadership and Organizational Risks Findings and Recommendations**

VHA requires leaders to conduct an institutional disclosure when an adverse event causes or may cause the patient's death or serious injury.<sup>23</sup> The OIG requested adverse patient safety events that occurred from February 5, 2018, through March 20, 2022, and reviewed events reported by healthcare system staff. The OIG found that leaders did not consistently conduct institutional disclosures for sentinel events that may have contributed to patients' death. Failure to disclose sentinel events can erode VA's core values and reduce patients' trust in the organization. The Director reported a lack of a consistent process to complete institutional disclosures.

### **Recommendation 1**

1. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures leaders conduct institutional disclosures for all applicable sentinel events.

Healthcare system concurred.

Target date for completion: November 30, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. The Patient Safety Manager developed a written process for recognizing and sharing sentinel events with the Director, Chief of Staff, Risk Manager, and other appropriate Phoenix VA Health Care System leadership. The Risk Manager documents the indication for institutional disclosure in a secure database. The Risk Manager will monitor and report compliance with the completion of applicable institutional disclosures to the Quality and Patient Safety Board monthly. The Chief of Quality and Patient Safety reports the Quality and Patient Safety Board meeting minutes monthly at Governing Council meetings which the Chief of Staff attends. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months.

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<sup>23</sup> VHA Directive 1004.08.

## Quality, Safety, and Value

VHA strives to provide healthcare services that compare “favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience.”<sup>24</sup> To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.<sup>25</sup> Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).<sup>26</sup>

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system’s committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system’s processes for conducting peer reviews of clinical care.<sup>27</sup> Peer reviews, “when conducted systematically and credibly,” reveal areas for improvement (involving one or more providers’ practices) and can result in both immediate and “long-term improvements in patient care.”<sup>28</sup> Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.<sup>29</sup>

Finally, the OIG assessed the healthcare system’s culture of safety.<sup>30</sup> VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

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<sup>24</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

<sup>25</sup> VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (VHA rescinded and replaced this directive with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

<sup>26</sup> VHA Directive 1100.16.

<sup>27</sup> A peer review is a “critical review of care, performed by a peer,” to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

<sup>28</sup> VHA Directive 1190.

<sup>29</sup> VHA Directive 1190.

<sup>30</sup> A culture of safety is “the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.” “Hospital Survey on Patient Safety Culture: User’s Guide,” Agency for Healthcare Research and Quality, July 2018, accessed October 3, 2022, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf>.

## Quality, Safety, and Value Findings and Recommendations

VHA requires a peer review committee to recommend “non-punitive, non-disciplinary actions to improve the quality of health care delivered or the utilization of health care resources” for Level 3 peer reviews.<sup>31</sup> The OIG did not find evidence the Protected Peer Review Committee recommended individual improvement actions for final Level 3 peer reviews. This may have prevented improvements in providers’ provision of patient care. The Chief, Quality Safety and Improvement stated that the Chief of Staff chairs the Protected Peer Review Committee and several leaders had served in the position during the OIG assessment period. The chief also reported believing the leaders were unaware of the requirement to document recommendations.

### Recommendation 2

2. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures the Protected Peer Review Committee recommends improvement actions for all Level 3 peer reviews.

Healthcare system concurred.

Target date for completion: November 30, 2023

Healthcare system response: The Director reviewed the recommendation and did not identify any additional reasons for noncompliance. The Protected Peer Review Committee reviewed the required action(s) to be taken for Level 3 peer reviews during their April 2022 meeting. The Risk Manager will ensure the Protected Peer Review Committee’s meeting minutes include the committee’s recommended improvement action(s) for all Level 3 peer reviews. The Risk Manager will email the committee’s recommendation(s) for improvement to the applicable provider’s supervisor or service chief, monitor and track the recommendations through completion on a secure tracking log, and report the monthly status to the Protected Peer Review Committee. The numerator is the number of Level 3 peer reviews with Protected Peer Review Committee recommended improvement action(s). The denominator is the number of Level 3 peer reviews. The Risk Manager will report the numerator, denominator, and compliance percentage monthly to the Medical Executive Board until a minimum of 90 percent compliance is maintained for six consecutive months. The Director reviews the Medical Executive Board minutes as indicated with a signature.

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<sup>31</sup> A peer review is assigned a Level 3 when “most experienced and competent clinicians would have managed the case differently.” VHA Directive 1190.

VHA requires an executive-level medical committee to review a peer review committee's summary analysis every quarter.<sup>32</sup> The OIG found that minutes for the Medical Executive Board (the system's executive-level medical committee) meetings from March 1, 2021, through February 28, 2022, lacked evidence the board reviewed the Protected Peer Review Committee's summary analysis in two of four quarters. Inconsistent review of quarterly summary analyses may have resulted in the Medical Executive Board's failure to identify clinical practice trends, determine the need for further action, and monitor the effectiveness of quality improvement initiatives. The Chief, Quality Safety and Improvement acknowledged a lack of oversight in ensuring the Protected Peer Review Committee presented summary analyses to the Medical Executive Board.

### Recommendation 3

3. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures the Medical Executive Board reviews the Protected Peer Review Committee's summary analysis quarterly.<sup>33</sup>

Healthcare system concurred.

Target date for completion: Completed.

Healthcare system response: The Director reviewed the recommendation and did not identify any additional reasons for noncompliance. Beginning March 2022, the Protected Peer Review Committee resumed reporting the quarterly summary analysis to the Medical Executive Board. The Medical Executive Board documented review of the analysis quarterly within its meeting minutes. The Medical Center Director reviewed and signed the Medical Executive Board minutes for six consecutive months.

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<sup>32</sup> The summary includes analysis of peer review trends and aggregate data such as the number of peer reviews completed, number of peer review assignments moved to a lower level, and the number of those moved to a higher level. VHA Directive 1190.

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

## Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently.”<sup>34</sup> These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care “without supervision or direction, within the scope of the individual’s license, and in accordance with individually-granted clinical privileges.”<sup>35</sup>

Privileges need to be specific and based on the individual practitioner’s clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP’s credentials and service chief’s recommendation to determine whether “clinical competence is adequately demonstrated to support the granting of the requested privileges,” and submits the final recommendation to the facility director.<sup>36</sup> LIPs are granted clinical privileges for a limited time and must be repriviledged prior to their expiration.<sup>37</sup>

VHA defines the Focused Professional Practice Evaluation (FPPE) as “a time-limited period during which the medical staff leadership evaluates and determines the practitioner’s professional performance.”<sup>38</sup> The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.<sup>39</sup> Facility leaders must also monitor the LIP’s performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.<sup>40</sup>

VHA’s credentialing process involves the assessment and verification of healthcare practitioners’ qualifications to provide care and is the first step in ensuring patient safety.<sup>41</sup> Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the Chief of Staff. VHA also requires facilities to have credentialing

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<sup>34</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

<sup>35</sup> VHA Handbook 1100.19.

<sup>36</sup> VHA Handbook 1100.19.

<sup>37</sup> VHA Handbook 1100.19.

<sup>38</sup> VHA Handbook 1100.19.

<sup>39</sup> VHA Handbook 1100.19.

<sup>40</sup> VHA Handbook 1100.19.

<sup>41</sup> VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.<sup>42</sup>

The OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members who had a completed FPPE or Ongoing Professional Practice Evaluation.

## **Medical Staff Privileging Findings and Recommendations**

VHA requires FPPE criteria “to be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process[,] and approved by the Director.”<sup>43</sup> The OIG found that FPPEs lacked evidence practitioners were consistently aware of and had accepted the evaluation criteria before service chiefs initiated the FPPE process. This could have resulted in practitioners misunderstanding FPPE expectations. The Chief of Staff cited the lack of a standardized LIP notification process for FPPE criteria. The OIG did not make a recommendation, but without VHA requiring documentation that practitioners were informed of the criteria used to evaluate their performance, facility leaders cannot monitor compliance.

VHA also requires service chiefs to establish additional service-specific clinical privileging criteria.<sup>44</sup> The OIG found that Ongoing Professional Practice Evaluations did not consistently contain service-specific criteria. This may have resulted in insufficient data to support decisions to continue the practitioners’ clinical privileges. Furthermore, the lack of a thorough competency evaluation could have adversely affected quality of care and patient safety. The Deputy Chief of Staff acknowledged that service-specific criteria were inadvertently omitted when the Medical Executive Board reviewed and approved the Ongoing Professional Practice Evaluation forms.

### **Recommendation 4**

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs establish service-specific criteria for professional practice evaluations.

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<sup>42</sup> Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, “Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020,” December 16, 2020.

<sup>43</sup> VHA Handbook 1100.19.

<sup>44</sup> For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty. VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: November 30, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. The revised and approved professional practice evaluation forms will include service-specific criteria obtained from the VA Central Office as well as facility-specific indicators. The numerator is the number of completed professional practice evaluation forms that include service-specific criteria. The denominator is the number of completed professional practice evaluations. The Health System Specialist, Credentialing Analyst will monitor and track the number of completed professional practice evaluations to include those with and without service-specific criteria and email that information to the Chief of Quality and Patient Safety. The Chief of Quality and Patient Safety will report the numerator, denominator, and percentage compliance to the Medical Executive Board, chaired by the Chief of Staff, until 90 percent compliance is maintained for six consecutive months.

## Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.<sup>45</sup> The physical environment of a healthcare organization must not only be functional but should also promote healing.

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG assessed compliance in selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers (CLCs), where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.<sup>46</sup>

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.<sup>47</sup> VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times in emergencies and contribute to a safe healthcare environment.<sup>48</sup>

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected the following patient care areas:

- CLC (Liberty and Old Glory neighborhoods)

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<sup>45</sup> VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded and replaced this directive with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.)

<sup>46</sup> CLCs were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

<sup>47</sup> Centers for Disease Control and Prevention – National Center for Health Statistics, “Drug Overdose Deaths in the U.S. Top 100,000 Annually,” accessed March 22, 2022, [https://www.cdc.gov/nchs/pressroom/nchs\\_press\\_releases/2021/20211117.htm](https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm).

<sup>48</sup> Opioids are medications that are “effective at reducing pain” but “when taken in excess, can lead to respiratory arrest.” Naloxone is a highly effective treatment for reversing an opioid overdose. “Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit,” VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, “Automated External Defibrillators (AEDs),” accessed December 16, 2021, <https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds>. “Pharmacy Benefits Management Services,” Department of Veterans Affairs, accessed October 6, 2021, [https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid\\_Overdose\\_Education\\_and\\_Naloxone\\_Distribution.asp](https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp).

- Dialysis clinic
- Emergency department
- Medical/surgical inpatient unit (2C)
- Mental health inpatient unit (5C)
- Post-anesthesia care unit
- Primary care clinic (Emerald)
- Women’s health clinic (Amethyst)

## **Environment of Care Findings and Recommendations**

VHA requires staff to conduct environment of care inspections at “a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year” in patient care areas and document completion of each inspection.<sup>49</sup> The OIG found that staff did not complete one of two required inspections in FY 2021 in the Allergy, Diamond-Cardiology, Diamond-Dermatology, and primary care Emerald and Gold clinics. As a result, staff may not have identified potential deficiencies and patient safety risks. The Safety Engineer stated that staff inadvertently omitted these areas.

### **Recommendation 5**

5. The Executive Director determines the reasons for noncompliance and ensures staff conduct environment of care inspections in patient care areas at the required frequency.<sup>50</sup>

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<sup>49</sup> VHA Directive 1608.

<sup>50</sup> The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Healthcare system concurred.

Target date for completion: Completed.

Healthcare system response: The Director reviewed the recommendation and did not find any other areas of non-compliance. The Safety Engineer Supervisor updated the Performance Logic Program's (the program used to track and trend environment of care inspections) location names with more concise descriptions of each building and patient care area. The Safety Engineer Supervisor ensured the required environment of care inspections were completed. A clinical engineer ensured documentation of the required and completed inspections in the Performance Logic Program. The numerator was the number of completed patient care area inspections. The denominator (25) was the number of all patient care areas requiring an environment of care inspection. The Safety Engineer Supervisor monitored compliance monthly and reported the numerator, denominator, and compliance percentage to the Environment of Care Board until a minimum of 90 percent compliance was met for six consecutive months. The Environment of Care Board meeting minutes are reported to the Administrative Executive Board which reports to the Governing Council, chaired by the Medical Center Director.

VHA requires staff to post signage to indicate areas that are subject to video recording.<sup>51</sup> The OIG found that the inpatient mental health unit and CLC had cameras in place for patient safety and surveillance. These cameras recorded, but there was no associated signage posted in the area. Recording in patient care areas without notice may violate individuals' right to privacy.

## Recommendation 6

6. The Executive Director determines the reasons for noncompliance and ensures staff post signage to indicate areas that are subject to video recording.<sup>52</sup>

Healthcare system concurred.

Target date for completion: Completed.

Healthcare system response: The Director reviewed the recommendation and did not identify any additional reasons for noncompliance. On April 20, 2022, the OIG's recommendation was discussed at the Environment of Care Board meeting. These meeting minutes were reported to the Administrative Executive Board. On May 17, 2023, Medical Media staff produced signage that read "This area is subject to video recording". Engineering staff posted the signage at the Community Living Center and the inpatient mental health units.

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<sup>51</sup> VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021.

<sup>52</sup> The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

## Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives

Suicide prevention remains the top clinical priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent “13.7 [percent] of suicides among U.S. adults.”<sup>53</sup> Additionally, “among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019.”<sup>54</sup>

VHA implemented various evidence-based approaches to reduce veteran suicides, including a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.<sup>55</sup> The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from emergency departments or urgent care centers and receive “structured post-discharge follow-up to facilitate engagement in outpatient mental health care.”<sup>56</sup> The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients’ discharge from the emergency department or urgent care center and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 50 randomly selected patients who were seen in the emergency department or urgent care center from December 31, 2020, through August 1, 2021.

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<sup>53</sup> Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

<sup>54</sup> Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*.

<sup>55</sup> Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy),” November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy),” November 23, 2022.)

<sup>56</sup> Deputy Under Secretary for Health for Operations and Management memo, “Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives,” October 17, 2019. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions,” October 1, 2021.)

## **Mental Health Findings and Recommendations**

The OIG made no recommendations.

## **Report Conclusion**

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided six recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

## Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines six OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Executive Director and Chief of Staff. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

**Table A.1. Summary Table of Recommendations**

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> <li>Leaders conduct institutional disclosures for all applicable sentinel events.</li> </ul>
Quality, Safety, and Value	<ul style="list-style-type: none"> <li>The Protected Peer Review Committee recommends improvement actions for all Level 3 peer reviews.</li> <li>The Medical Executive Board reviews the Protected Peer Review Committee’s summary analysis quarterly.</li> </ul>
Medical Staff Privileging	<ul style="list-style-type: none"> <li>Service chiefs establish service-specific criteria for professional practice evaluations.</li> </ul>
Environment of Care	<ul style="list-style-type: none"> <li>Staff conduct environment of care inspections in patient care areas at the required frequency.</li> <li>Staff post signage to indicate areas that are subject to video recording.</li> </ul>
Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives	<ul style="list-style-type: none"> <li>None</li> </ul>

## Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 22.<sup>1</sup>

**Table B.1. Profile for Phoenix VA Health Care System (644)  
(October 1, 2018, through September 30, 2021)**

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020 <sup>†</sup>	Healthcare System Data FY 2021 <sup>‡</sup>
Total medical care budget	\$770,238,893	\$956,546,052	\$1,118,839,616
Number of:			
• Unique patients	99,918	101,334	111,222
• Outpatient visits	1,190,424	1,128,399	1,265,351
• Unique employees <sup>§</sup>	3,181	3,359	3,412
Type and number of operating beds:			
• Community living center	104	104	104
• Domiciliary	24	24	24
• Medicine	82	82	82
• Mental health	48	48	48
• Surgery	36	36	36
FY to date average daily census:			
• Community living center	37	24	21
• Domiciliary	23	16	11
• Medicine	57	59	80
• Mental health	31	30	34

<sup>1</sup> VHA medical facilities are classified according to a complexity model; a designation of “1a” indicates a facility with “high volume, high risk patients, most complex clinical programs, and large research and teaching programs.” “Facility Complexity Model Fact Sheet,” VHA Office of Productivity, Efficiency & Staffing (OPES). An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
<ul style="list-style-type: none"> <li>Surgery</li> </ul>	12	8	7

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

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

\*October 1, 2018, through September 30, 2019.

†October 1, 2019, through September 30, 2020.

‡October 1, 2020, through September 30, 2021.

§Unique employees involved in direct medical care (cost center 8200).

## Appendix C: VISN Director Comments

### Department of Veterans Affairs Memorandum

Date: May 22, 2023

From: Interim Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Comprehensive Healthcare Inspection of the Phoenix VA Health Care System in Arizona

To: Director, Office of Healthcare Inspections (54CH06)  
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) Draft Report, Comprehensive Healthcare Inspection of the Phoenix VA Health Care System in Arizona.
2. Based on the thorough review of the report by VISN 22 leadership, I concur with the recommendations and submitted action plans of the Phoenix VA Health Care System.
3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

*(Original signed by:)*

Steven E. Braverman, MD  
Interim Network Director, VISN 22

## Appendix D: Healthcare System Director Comments

### Department of Veterans Affairs Memorandum

Date: May 22, 2023

From: Executive Director, Phoenix VA Health Care System (644/00)

Subj: Comprehensive Healthcare Inspection of the Phoenix VA Health Care System in Arizona

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of the Phoenix VA Health Care System in Arizona. I concur with the findings and recommendations in the report.
2. Phoenix VA Health Care System remains committed to ensuring our Veterans receive exceptional health care.

*(Original signed by:)*

Bryan C. Matthews

Executive Director, Phoenix VA Health Care System

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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