VA Office of Inspector General Response

Questions for The Honorable Michael J. Missal

Inspector General, U.S. Department of Veterans Affairs

Questions from Chairman Gerald E. Connolly

June 20, 2019, Hearing: "Ensuring Quality Healthcare for our Veterans"

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1. "Has the Office of Inspector General (OIG) engaged with medical center officials to create a matrix, requested by Chairman Connolly, that will allow Congress to effectively track the Washington, D.C. Veteran Affairs Medical Center (DC VAMC) progress in addressing the issues of concern described in your reports? What variables and information do you think should be included that would help Congress more easily track medical center progress at the DC VAMC?"

   The OIG is not currently involved in the creation of a matrix to track progress and improvements at the DC VAMC. The standards that govern the work of Inspectors General require that we remain independent and refrain from participating in management functions. That independence limits our ability to collaborate in setting specific goals or parameters for success on behalf of or in conjunction with the Department. However, the OIG's Critical Deficiencies report and the January 2019 Comprehensive Healthcare Inspection Program (CHIP) report on the DC VAMC provide a combined 58 recommendations to guide the development of action plans aimed at improving facility performance. The implementation of those action plans are tracked through the OIG follow-up process to ensure the DC VAMC is taking appropriate action.

   Additionally, as reported in the Critical Deficiencies report, the facility and Veterans Integrated Service Network (VISN) 5 received seven written reports detailing significant deficiencies, many of which were identified prior to the initial OIG site visit in March 2017. The medical center leadership should utilize those reports, as well as any ongoing and future reports, to design and implement action plans that will drive sustainable improvements.

2. "How will the OIG measure the medical center's success regarding a change in the culture of complacency?"

   The OIG follow-up process provides the ability to review indicators of progress, such as measurable improvements in inventory control and supply management and proper recording and reporting of patient safety events. Additionally, the OIG would consider improvements in employee and patient satisfaction scores to be a signal that the facility leadership remains focused on improving the culture of complacency.

3. "How frequently does the OIG conduct medical and administrative inspections of VA Medical Centers, including the DC VAMC?"

   The OIG conducts unannounced, triennial assessments of operations and quality control programs at Veterans Health Administration (VHA) medical facilities and issues the findings, known as CHIP reports. These reports focus on leadership within a facility and key factors that affect patient care, such as quality, safety, and value; the credentialing and privileging process; and the environment of care. Additionally, the OIG annually rotates high-interest subtopics in areas including mental health, women's health, high-risk processes, and medication management. The OIG will also conduct more urgent and immediate inspections based on indications or allegations that provide credible evidence of patient risk/harm or systemic failures at a VHA facility. Finally, the OIG is expanding its CHIP reviews to focus on VISN-level leadership in a more systematic way. These reviews are evaluating the stability of leadership positions within a VISN and the VISN's ability to support its medical facilities in reducing risks that could lead to unfavorable patient care experiences and unexpected outcomes.

   The OIG is also conducting reviews to assess the financial management and logistics processes within a VISN to ensure that VHA is implementing prudent financial practices and effectively managing its funds, programs, and resources. These financial reviews will address whether VA is acting as a good steward of public funds. As these reviews develop, OIG staff will provide additional information designed to help improve operations and provide timely and quality care to veterans.

4. "Does the OIG increase the number of medical center reviews at struggling VA facilities? If so, what metrics or events elicit an increase in reviews?"

   The OIG may increase oversight of a particular VHA facility based on indications of patient risk/harm or allegations of systemic failures. The OIG receives information from many sources – including the OIG Hotline, previous and ongoing OIG reviews, congressional inquiries, interviews during site visits, and media reports – and uses that data to inform our decisions. OIG staff may also conduct more frequent follow-up reviews to assess VA's progress in implementing recommendations when a facility appears unable to effectively address OIG findings. The follow-up visits to the DC VAMC are a good example of this, and these additional inspections help ensure issues do not remain unresolved over long periods of time.

5. "The star ranking system for VA is based on the Strategic Analytics for Improvement and Learning (SAIL) model. Does the OIG consider the SAIL ranking as an accurate account for the potential patient outcomes? If not, are there other metrics the public should use to evaluate the DC VAMC's quality of care?"

   SAIL data can be used to highlight VHA's best practices as well as identify quality of care issues that would justify increased attention or resources to better support underperforming services or processes. The OIG includes SAIL data in CHIP reports, but recognizes that the SAIL model has limitations in identifying or predicting all areas of clinical risk. As with any assessment of a

medical facility, potential patients need to consider a number of indicators of which SAIL data is only one, including patient surveys and research on areas of specialization.

6. "How could the OIG expand on its current reviews of medical facilities and incorporate patient satisfaction and patient reviews for VA medical centers?"

   The OIG does include VA's patient experience scores and employee satisfaction survey results in CHIP reports and compares selected patient experience survey scores for facility leaders to the VHA average. The OIG also discusses this data with facility leaders during our CHIP reviews to determine their level of engagement and whether they actively promote a culture where employees feel safe bringing forward issues and concerns.

7. "What is the OIG's assessment of the DC VAMC's hiring list and staffing analysis plan as provided in response to Recommendation 19 of the "Critical Deficiencies" report?"

   The facility provided a hiring list that includes 423 positions, each assigned a hiring priority of 1 (highest) to 5 (lowest). Because the OIG does not have knowledge of the specific staffing needs within each Service, the team did not attempt to independently evaluate whether the priority assignments were appropriate. It appeared, however, that VISN and facility Human Resources (HR) staff followed a reasonable process that involved service line managers to analyze staffing needs across the facility and recruit for active, approved, and budgeted positions. Furthermore, hiring actions have been occurring, primarily through a Workforce Management contract.

   The VHA HR Modernization and Shared Services model, initiated in October 2018 with completion due in 2020, consolidates transactional services and realigns facility HR operations under the VISN HR officer. While this model aims to streamline HR-related functions, the transition period, during which processes and relationships are being developed and tested, can present challenges. Given the DC VAMC's weakened staffing scenario and local HR inefficiencies, the facility is particularly vulnerable to service disruption caused by the modernization effort.

8. "The OIG's "Critical Deficiencies" report has many allegations of government waste, fraud, and abuse. What is the OIG's estimate of the total dollar amount attributable to mismanagement during the period in which they reviewed for the "Critical Deficiencies" report? Was the severity of the waste and fraud found at the DC VAMC in the "Critical Deficiencies" report unique to this facility or comparable to other low-performing facilities?"

   At the time of the OIG review, the DC VAMC lacked the necessary properly functioning administrative systems to be able to even estimate the total dollar amount attributable to mismanagement. Without proper documentation and reliable inventory control systems and supply chain management, it was impossible to forensically quantify the financial impact at the facility. While the OIG cannot compare the severity of the deficiencies the review team identified at the DC VAMC with other VHA facilities, in recent OIG experience, it was significant in its scope and scale.