



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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OFFICE OF INSPECTOR GENERAL
US DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS
US HOUSE OF REPRESENTATIVES
HEARING ON
THE CONTINUITY OF CARE: ASSESSING THE STRUCTURE OF
VA'S HEALTHCARE NETWORK
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Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, the Office of Inspector General (OIG) oversees the delivery of health care by the Veterans Health Administration (VHA), including examining the role of Veterans Integrated Service Networks (VISNs) in the governance of VA medical facilities located within each of their 18 networks.¹ The OIG's Office of Healthcare Inspections routinely reviews and publicly reports on the quality of health care VHA provides, as well as any risks to patient safety, across the nation. In many of these reviews, lack of oversight by VISN leaders and staff is a key contributor to identified deficiencies or adverse patient outcomes. Given its importance, the OIG has increased its focus on VISN leaders' roles and actions in supporting facility leaders and staff to deliver high-quality care. Through this effort, the OIG has repeatedly discovered inconsistent practices and inefficiencies that run counter to VHA's initiative to transform into a high reliability organization (HRO).

In February 2019, VHA's Office of Healthcare Transformation outlined definitive steps toward becoming an HRO grounded by the basic tenet of a "just culture." Within a just culture, personnel at every level understand and react to not just identifiable risks and errors, but any vulnerabilities that could lead to patient harm. Leaders that promote such accountability and react with transparency and fairness to their staff's misconduct and missteps help establish a culture in which staff feel not only responsible for, but also secure in, reporting all concerns.

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

When conducting work at VHA facilities, OIG teams often interview VISN leaders to gauge their understanding of the issues impacting their local facilities, and their role in supporting the facilities to remedy any weaknesses and risks to patients or personnel. Many VISN leaders’ responses demonstrate at best a “loose” understanding of problems related to staffing shortages, patient safety, and workplace culture. Repeatedly, quality management officers and chief medical officers within VISNs suggest problems can be attributed to failures of facility leaders to *bring* issues to their attention or request support—pointing to their lack of authority to require facilities to report events. A structure that permits such passive oversight will repeatedly fail to meet the needs of its patients.

THE CURRENT VISN STRUCTURE DOES NOT ENSURE ACCOUNTABILITY

The Government Accountability Office (GAO) recommended in June 2019 that the under secretary for health clearly define VISN roles and responsibilities for managing and overseeing medical centers.² Currently, GAO reports this recommendation remains open. However, VA projects publication in October 2024 of a directive that will include the roles and responsibilities of VISNs and medical centers as part of a set of core functions tailored to differentiate the authority and span of control for all VHA operational units, including management and oversight responsibilities. The policies and procedures in place at the VA Central Office regarding VISN oversight of medical facilities lack clearly defined and standardized responsibilities, leading to inconsistent oversight and deficient engagement with facility leaders.

The two reports published earlier this week on the VA Eastern Colorado Health Care System in Aurora provide more recent examples of disengaged VISN leaders.³ OIG reports focusing on the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico, and the Montana VA Health Care System also clearly demonstrate how VISN leaders’ failures to understand and carry out their duties can have serious consequences.⁴

² GAO, [Veterans Health Administration: Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities](#), June 19, 2019.

³ VA OIG, [Extended Pause in Cardiac Surgeries and Leaders’ Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora](#), June 24, 2024; VA OIG, [Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety](#), June 24, 2024.

⁴ VA OIG, [Deficiencies in Documentation of Reusable Medical Device Reprocessing and Failures in VISN 22 Oversight of Sterile Processing Service at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico](#), April 30, 2024; VA OIG, [Chief of Staff’s Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders’ Failures at the Montana VA Health Care System in Helena](#), February 6, 2024.

Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact of Resident Education at the VA Eastern Colorado Health Care System in Aurora

An OIG healthcare team reviewed allegations that facility leaders implemented staffing changes that adversely affected the provision of cardiothoracic (CT) surgeries. The OIG determined that the facility director, chief of staff, deputy chief of staff for inpatient operations, and the acting chief of surgery proceeded with plans to resume CT surgeries following an 11-month pause due to insufficient staffing without notifying or seeking approval from VISN and VA Central Office leaders. During an interview with the VISN director, the OIG escalated concerns regarding the facility's readiness to resume surgeries and the VISN's possible lack of awareness of these plans. The VISN director acknowledged a lack of awareness and formally requested an evaluation by the National Surgery Office.

In the medical intensive care unit (ICU), facility leaders also suddenly changed the operating model without any notification to, or preparation for, clinical staff. A transition from an open to a closed ICU model (a shift that changes which care providers have primary responsibility) was discussed in December 2022, with a goal of June 2023 for implementation, as recommended by an assessment in 2021 by a VHA team that included the national director for pulmonary and critical care.⁵ Yet, the chief of staff made an abrupt decision to accelerate that transition in January 2023 after concerns were raised about the privileging status of the attending ICU hospitalists. The sudden model change was made without adequate planning and staff input, which led to inadequate resident supervision, an ineffective teaching environment, and fractured trust among clinical staff. More effective VISN oversight as well as communication between facility and VISN may have provided an opportunity to reconcile privileging concerns and ICU operations in a manner that engaged clinical staff and other stakeholders, including the academic affiliate whose residents were affected by the changes.

VA concurred with the OIG's six recommendations and provided acceptable corrective action plans. The follow-up process begins 90 days from publication.

Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety

This second report focused on allegations that senior leaders failed to practice HRO principles and created a culture of fear and retaliation among staff at the facility. The OIG found key senior leaders fostered an environment in which a significant number of clinical and administrative leaders and frontline staff from multiple service lines felt psychologically unsafe, deeply disrespected, and dismissed. They feared that speaking up or offering a difference of opinion would result in reprisal. Further, instability in top positions at the service level affected continuity in strong leadership, with many clinical service and section-level resignations and vacancies. Former medical facility leaders cited

⁵ An open ICU model includes multiple physicians or teams, whether assigned to the ICU or not, to provide care to a patient in the ICU. A closed ICU model includes only the team specifically assigned to the ICU to manage all ICU patients.

that a psychologically unsafe work environment was a major factor in their decision to leave facility employment. The OIG made seven recommendations that VA concurred with and provided acceptable action plans for. The follow-up process will begin 90 days after publication.

In both reports about the Aurora healthcare system, events and interviews substantiate that this facility's culture and key functions were crumbling for close to two years. There were clear signs: sudden exits of critical clinical leaders, a fractured relationship with an academic affiliate, and a prolonged closure of cardiothoracic surgery services. Yet, the OIG team's interview with the then VISN chief medical officer revealed a leader who described limited awareness of the gravity of the issues, stating he "hadn't heard much noise from the Director." Additional interviews with current VISN leaders reflected frustration with the passivity of this former VISN chief medical officer. This pervasive passivity the OIG has seen in multiple VISNs contributes to the ongoing governance concerns being spotlighted in today's hearing.

Deficiencies in Documentation of Reusable Medical Device Reprocessing and Failures in VISN 22 Oversight of Sterile Processing Service at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico

The OIG received allegations that the facility did not take action to address problems identified during a VISN inspection of the facility's sterile processing service (SPS) operations. Patients were at risk for infection when reusable medical devices used in patient care lacked documentation that high-level disinfection had been conducted. The OIG team determined that while there were multiple VISN inspection findings and recommendations related to facility SPS operations, the VISN delayed official notifications of them to facility leaders. During interviews, the OIG team concluded that VISN and facility leaders had different expectations as to whether facility actions should have been initiated prior to a formal VISN report being issued. However, had the VISN assumed a more active role, leaders could have more quickly recognized and addressed delays in corrective actions. The OIG found the lack of VISN oversight to hold the facility accountable to a timely remediation plan resulted in delayed implementation of sustainable, corrective actions for more than a year from the original findings.

Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena

The highest-level clinical leader in a VA medical facility is the chief of staff. Oversight of their clinical practice requires VISN support. In this report, the OIG found that a chief of staff was practicing gynecologic and obstetric care without privileges. The chief of staff's failure to follow evidence-based clinical standards for care placed one patient and her fetus at risk. Another patient was given an inadequate postoperative antibiotic. Finally, preoperative testing was not completed for surgical procedures in 32 of 35 cases. Despite the clear violation of privileging policy that is critical to safe clinical practice, when facility and VISN leaders were questioned regarding accountability, the VISN chief medical officer claimed the responsibility was the medical center director's. Because of undefined roles and responsibilities of VISN leaders, and absent facility leaders' initiative to seek out VISN support, patients were placed at unnecessary risk.

VISN LEADERS ARE NOT PROVIDING THE NECESSARY SUPPORT TO FACILITY LEADERS TO DEVELOP AND MAINTAIN A CULTURE OF PATIENT SAFETY

Healthcare systems committed to patient safety routinely follow protocols that prioritize high-quality care. They have structured and proactive quality and safety management oversight teams. They exercise a shared responsibility to recognize and report perceived risks while holding individuals and leaders accountable for ensuring patient safety is a continuous activity. VHA is this country's largest integrated healthcare system, and the volume and complexity of patient encounters require deliberate and clear lines of communication and information sharing. Dotted reporting lines, optional participation in sharing critical metrics, and confusion over authority undermine the essential functions of medical facilities and further highlight the failure of the current VISN structure to ensure consistent delivery of safe care to patients.

Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama

In this report, the OIG found that the facility's patient safety manager was derelict in performing required essential safety functions, such as reviewing and addressing reported incidents and completing root cause analyses for over a year, which essentially paralyzed the facility's entire patient safety program.⁶ Facility and VISN leaders were completely unaware. The VISN patient safety officer acknowledged the inconsistent attendance of the patient safety manager at weekly calls and VISN-led patient safety committee meetings, but also noted that facility patient safety manager's participation was optional. The VISN patient safety officer did not know the extent to which the facility's patient safety program was out of compliance with VHA requirements because of an overreliance on briefings (from which the facility manager was often missing) and insufficient proactive outreach that would have revealed incident reporting, reviews, and remediations were not being done. This passive oversight is not in keeping with HRO principles.

The OIG made 11 recommendations, of which two called on the VISN to ensure the reporting and tracking of actions taken on patient safety events. All recommendations have been closed as implemented.

Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia

This report outlines failures in responsibility at multiple levels of VHA, including the VISN, facility, and service line, in reacting to deficiencies in sterile processing at the medical center.⁷ VHA Directive 1116(2) charged the VISN SPS Management Board with the oversight of SPS and reprocessing

⁶ VA OIG, [*Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama*](#), February 27, 2023.

⁷ VA OIG, [*Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia*](#), March 6, 2024.

of critical and semicritical reusable medical devices at all medical facilities in the VISN.⁸ In addition, the VISN SPS Management Board is required to conduct a VISN-led inspection at each facility. After each inspection, the VISN develops recommendations to improve the reviewed processes. While the VISN SPS lead is responsible for ensuring that action plans to address the recommendations are followed to completion, the OIG's review of the VISN SPS Management Board's meeting minutes found no documentation to support that this occurred.

Two of the nine recommendations from this report were addressed to the VISN director: The first is to review the facility's water management program and ensure its compliance with VHA guidance and monitor future compliance. The second is to make certain that the VISN SPS Management Board review the facility's water test results and that any necessary corrective actions be taken and reported to the National Program Office. These recommendations are open and the OIG will review VA's progress on implementing them during the routine follow-up process starting 90 days after the report's publication.

Cyclical Inspections Find Deficiencies in Staff Privileging

During the OIG's proactive cyclical inspections of medical facilities, healthcare teams found deficiencies in medical staff privileging activities, including failures to conduct ongoing and focused performance evaluations that help ensure providers are practicing competently. Several facilities that were visited for the fiscal year 2023 OIG Comprehensive Healthcare Inspection Program (CHIP) were found to have the same weaknesses related to these activities as those in prior OIG reports. Facilities in Augusta, Maine; Roseburg, Oregon; and Manchester, New Hampshire, are just three examples where repeat findings of deficiencies in medical staff privileging prompted OIG teams to direct recommendations to VISN leaders to ensure appropriate attention and support are provided to facilities struggling to comply with these critical activities.⁹

Reporting to State Licensing Boards

The impact of failed internal VISN oversight of quality and competency of healthcare providers extends beyond the walls of VA's hospitals and clinics. The OIG has repeatedly reported on VISN breakdowns in ensuring that facilities comply with policies to report providers who do not meet acceptable care standards to state licensing boards. Typically, the facility has the responsibility to begin the process to report a provider to a state licensing board. However, in the Montana VA Health Care System case referenced earlier, there was confusion as to whether the VISN chief medical officer and the VISN credentialing and privileging team should be responsible because the chief of staff was a member of the

⁸ VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016, was in place during the time of the events discussed in the report. It was rescinded and replaced by VHA Directive 1116, *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023.

⁹ VA OIG, [Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta](#), April 3, 2024; VA OIG, [Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon](#), May 15, 2024; VA OIG, [Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire](#), March 6, 2024.

executive leadership team. After the facility failed to report the chief of staff to the state licensing boards for his substandard gynecologic care, he resigned from his VA position and was able to practice medicine in the state of California.

VISN LEADERS HAVE LIMITED PARTICIPATION IN CRITICAL AND COSTLY DECISIONS RELATED TO FACILITY STAFFING AND REFERRALS OF VETERANS TO COMMUNITY CARE

In fiscal year 2022, more than 40 percent of veterans were provided care through the Veterans Community Care Program (VCCP), with that number continuing to rise.¹⁰ The magnitude of the related increasing costs and staffing to manage these referrals are significant and warrant standardized VISN-level coordination. There should be more effective controls of clinical and administrative resources to make the most efficient and effective use of taxpayer dollars while meeting the needs of veterans seeking care.

Recently published CHIP reports highlight the massive expense of community care and the burdens placed on facilities to coordinate referrals. For example, in a recent inspection of the VA Eastern Kansas Health Care System in Topeka, the OIG noted that its fiscal year 2022 annual medical care budget of \$504,398,232 had increased by approximately 24 percent compared to the previous year's budget of \$406,670,320.¹¹ The facility director and associate director reported spending had increased due to community care expenditures. In another inspection of the VA Maryland Health Care System in Baltimore, the director reported in an interview with the OIG team that nearly 100 personnel were recruited to just schedule and coordinate community care for veterans.¹²

A recent OIG report examined the high usage of community care services for primary care, the impact of that use, and leaders' oversight of VA outpatient clinics at the VA Loma Linda Healthcare System in California.¹³ The OIG found that after a new company assumed management of five community-based outpatient clinics, the contractor's staffing challenges limited the number of patients that clinic staff could see within prescribed timeframes. As a result, system leaders paused enrollment of new patients at all five community-based outpatient clinics and referred patients for primary care to the community.

However, the lack of oversight of contracted community-based outpatient clinics, and frequent changes of leaders at the VA healthcare system and the new company, highlighted an opportunity for VISN oversight and support of management of primary care services. In response to the OIG findings, the VISN has committed to collaborating on an assessment of the management of the community-based

¹⁰ VHA Office of Integrated Veteran Care, *VHA Community Care Growth Trends Briefing*, March 2024.

¹¹ VA OIG, [Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka](#), April 25, 2024.

¹² VA OIG, [Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore](#), May 2, 2024.

¹³ VA OIG, [Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California](#), April 23, 2024.

outpatient clinic steering committee and will provide ongoing programmatic monitoring through the VISN 22 Community Care Operational Dashboard. This collaboration is imperative if the healthcare system and VISN leaders want to return patients for primary care to the system, as they stated.

In the coming weeks, the OIG will publish its first proactive cyclical Care in the Community review of the VISN 9 VA Midsouth Healthcare Network.¹⁴ This report will reveal the significant challenges this VISN is facing in ensuring timely access to high-quality care in the community for its veterans. During interviews, the OIG team asked VISN 9 and facility leaders to share top concerns for their community care programs overall. These included care coordination, quality of care, and increasing costs. Beyond the well-known administrative challenges of trying to obtain medical documentation from community providers, leaders also stated that contractual agreements with third-party administrators of community care can impede required VISN oversight of the administrators' quality assessments and any subsequent corrective actions. VISN leaders also felt that because of these agreements, they had little ability to control costs.

With pending reductions in some VHA staffing and persistent staffing shortages in other critical clinical positions, the VISNs should consider their oversight role regarding financial and staffing decisions of medical facilities. This would help align available resources and community care expectations. Every decision must be informed and strategic, guided by an oversight structure that is standardized and data-driven.

CONCLUSION

The OIG has repeatedly published healthcare reports that find there are effective and comprehensive VHA policies and skilled and dedicated staff aggressively working to carry them out to provide high-quality and timely care to veterans. Yet, OIG oversight teams also continue to find the inconsistent application or misinterpretation of policy, insufficient VA personnel training, and other issues that could be mitigated by a clear and consistent structure of authority and accountability. Such a structure would clarify roles and responsibilities for those who could track and identify trends in noncompliance in real time and intervene proactively. Knowing that suicide prevention is the top priority for VHA, I want to reiterate the importance of how such a structure cannot only help advance its goals but also make a real difference in the lives of veterans. Despite clear policy and the recognized priority of using simple screening tools to assess veterans for suicide risk, the OIG has found that compliance across the system remains poor. In light of such performance, exploring options to monitor and mitigate barriers to complying with the most basic activities of suicide prevention—including risk assessments, safety plans

¹⁴ VISN 9 includes VA healthcare facilities affiliated with the Lexington VA Health Care System in Kentucky; the Tennessee Valley Healthcare System in Nashville and Murfreesboro, Tennessee; James H. Quillen VA Medical Center in Mountain Home, Tennessee; the Lt. Col. Luke Weathers, Jr. VA Medical Center in Memphis, Tennessee; and the Robley Rex VA Medical Center in Louisville, Kentucky.

for high-risk patients, safe storage discussions regarding firearms, and the necessary consultations—must be considered, in addition to the need for increased oversight of facilities enterprise-wide.

VHA care has evolved and expanded dramatically since the creation of the VISN structure. The size of VHA, the increasing demands of meeting complex healthcare needs, the escalating cost of health care, and the simultaneous implementation of massive initiatives—such as community care, the PACT Act, and electronic healthcare record modernization—require a standardized internal oversight structure that can assume accountability for the efficient and effective implementation of these high-cost but necessary efforts. We owe it to veterans who put their trust in VA, to the personnel working daily to meet their needs, and to the taxpayers who expect strong stewardship of their dollars. The OIG strongly encourages VA leaders at every level to use oversight reports as risk assessment tools to proactively address identified vulnerabilities in their own offices, networks, and facilities. The findings should also stimulate discussions about the VISN structure and its role in ensuring and supporting consistent high-quality care to veterans.

Madam Chair, this concludes my statement. I would be happy to answer any questions you or members of the subcommittee may have.