



FOR IMMEDIATE RELEASE
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Press Release
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VA OIG reports released on negative culture, ICU at VA ECHCS

AURORA – The Department of Veterans Affairs Office of the Inspector General released two related reports today, June 24, 2024, examining allegations that senior leaders created a culture of fear at the VA Eastern Colorado Health Care System and reviewing how facility leaders' actions may have impacted intensive care unit coverage, patient care, and resident education.

The OIG determined that the breadth of the allegations warranted two separate reports: "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" and "Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety." [Both reports can be found on the OIG website.](#)

As outlined in the OIG report, four leaders at VA Eastern Colorado Health Care System were identified as creating a culture that negatively impacted staff. While these investigations were ongoing, in October 2023, Network Director Sunaina Kumar-Giebel detailed the Director and Chief of Staff to temporary assignments away from the health care system and the other two leaders resigned.

The OIG did not substantiate any patient harm in these investigations. However, VA recognizes that a negative employee culture can have a negative impact on patient experience, and the Interim leadership at VA ECHCS is focused on creating a psychologically safe and healthy environment for staff.

We appreciate the work of the Office of the Inspector General, which helps us better serve our nation's Veterans, and we fully agree with the OIG's recommendations. We have taken immediate action to prevent issues like this from happening again, including:

- When cultural concerns became apparent in August 2023, Network Director Sunaina Kumar-Giebel brought several VA leaders to VA ECHCS for listening sessions with staff. These leaders included the Executive Director of the National Center for Organizational Development and several other VHA senior leaders. Based on the feedback from these sessions and initial feedback from the OIG, Kumar-Giebel detailed the VA ECHCS Director and Chief of Staff to positions outside of VA ECHCS while investigations were ongoing.
- Dr. Michael Moore, Deputy Medical Center Director at Little Rock VAMC, served as Interim Director from November 2023 to March 2024. During this time Amir

Farooqi, Medical Center Director at the Central Alabama VA Health Care System, was brought in to serve as a Special Advisor to the Network Director.

- In March 2024, Mr. Amir Farooqi became the Interim Director and Dr. Vicki Callahan the Interim Chief of Staff.
- Under the interim leadership, several actions have been taken aimed at fostering a culture of openness, inclusivity, and continuous improvement within the organization. Interim leadership created an "Ask the ELT" employee feedback tool, increased the frequency of staff town halls to monthly, and started a project to revamp daily staff huddles. These actions represent a significant shift towards a more inclusive, transparent, and proactive culture at the VA ECHCS. By fostering open communication, recognizing staff efforts, and continuously improving operations, the interim Director and COS are working to ensure that the VA ECHCS can effectively meet the needs of the veterans it serves.
- VA Eastern Colorado Health Care System (VA ECHCS) developed medical center policy (MCP) 11-55 Call Escalation of Communication to standardize VA ECHCS' processes and procedures for the escalation of communication to promote patient safety. The policy underwent extensive review among subject matter experts and stakeholders and was finalized March 2024.
- VA ECHCS will ensure communication of the status of the organization's journey towards a high reliability organization (HRO) are reported through the regularly recurring VISN healthcare operations committee, which will include data on frontline staff training, supervisor training, and team training.
- Veteran Integrated Service Network (VISN 19) established a new Office of Oversight for the Network. This office will incorporate High Reliability Organization (HRO) principles by conducting additional comprehensive oversight operations across the network, independent of already-existing oversight bodies such as OIG and Office of Medical Inspector. The purpose of this office is to review operations at the network and facility level to identify gaps and vulnerabilities within the system and work with subject matter experts at all levels within the department to develop lasting solutions to address them.

These improvements will prevent similar situations in the future. Colorado Veterans deserve no less.

For more information or to request interviews, contact [\(720\) 215-6458](tel:7202156458) or VHAECHPAO@va.gov.

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