



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection Summary Report:
Evaluation of Quality, Safety,
and Value in Veterans
Health Administration
Facilities, Fiscal Year 2020



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Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
OIG	Office of Inspector General
QSV	quality, safety, and value
RCA	root cause analysis
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration



Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years. The OIG selects and evaluates specific areas of focus each year.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected quality, safety, and value (QSV) program requirements for processes related to committees with QSV oversight functions, protected peer reviews of clinical care, utilization management (UM), and patient safety.

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG reviews.¹ The findings in this report may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG found general compliance with many of the selected requirements. However, the OIG identified weaknesses with

- implementation of improvement actions from the committee responsible for QSV oversight,
- peer review of all applicable deaths within 24 hours of admission to the hospital,
- peer review of all suicide deaths that occur within seven days after discharge from an inpatient mental health unit,
- quarterly review of the peer review committee's summary analysis by the executive-level medical committee,

¹ Fiscal year 2020 began October 1, 2019, and ended September 30, 2020.

- documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database,²
- inclusion of required processes in root cause analyses, and
- implementation and monitoring of approved improvement actions resulting from root cause analyses.

The OIG noted repeat findings from the fiscal year 2018 and 2019 QSV evaluations for peer review of all applicable deaths within 24 hours of admission, executive-level medical committee quarterly review of summaries of the peer review committees' work, and documentation of physician UM advisors' decisions in the National UM Integration database.³ VHA is implementing or recently completed improvement actions related to these findings. The OIG made no new recommendations.

Conclusion

The OIG conducted detailed inspections at 36 VHA facilities to ensure the facilities implemented selected QSV program processes. The OIG subsequently issued four recommendations for improvement to the Acting Under Secretary for Health in conjunction with Veterans Integrated Service Network directors and facility senior leaders. VHA leaders should use the results in this report to improve operations and clinical care at the facility level. The recommendations address findings that may eventually interfere with the delivery of quality health care.

² VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019. UM reviews include evaluating the “appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.” (This directive was rescinded and replaced with VHA Directive 1117, *Utilization Management Program*, October 8, 2020.)

³ VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report No. 19-07040-243, October 10, 2019; VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, Report No. 20-01994-18, November 24, 2020.

Comments

The Deputy to the Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health, agreed with the comprehensive healthcare inspection findings and recommendations (see appendix C, page 13, and the responses within the body of the report for the full text of the executive's comments.) The OIG noted that action plans lacked specific detail and will monitor implementation during the follow-up process until identified deficiencies are resolved.



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

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Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

While the OIG selects and evaluates specific areas of focus on a rotating basis each year, the evaluation of VHA facilities' quality, safety, and value (QSV) programs is an ongoing review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.¹ These leaders are directly accountable for program integration and communication within their level of responsibility.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected QSV program requirements for processes related to committees with responsibility for QSV oversight functions, protected peer reviews of clinical care, utilization management (UM), and patient safety.

To determine whether VHA implemented and incorporated OIG-identified key processes for quality and safety into local activities, the OIG evaluated facility committees responsible for QSV oversight functions; their ability to review data, information, and risk intelligence; and their ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed facilities' processes for conducting protected peer reviews of clinical care.² Protected peer reviews, "when conducted systematically and credibly", reveal areas for improvement (involving one or more providers' practices) and can result in immediate

¹ Public Law 111-163, Title V, Section 505.

² VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. 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. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. § 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

and “long-term improvements in patient care.”³ Peer reviews promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.⁴ The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all suicide deaths that occur within seven days after discharge from an inpatient mental health unit⁵
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- Quarterly review of the peer review committee’s summary analysis by the executive-level medical committee

Next, the inspection teams assessed facilities’ “UM Program, a key component of VHA’s Quality Management System, [that] provides vital tools for managing quality and resource utilization. It strives to ensure the right care, in the right setting, at the right time, for the right reason utilizing evidence-based practice and continuous measurement and improvement.”⁶ Inspectors reviewed several aspects of the UM program:

- Completion of at least 80 percent of all required inpatient reviews
- Documentation of at least 75 percent of physician UM advisors’ decisions in the National UM Integration database
- Interdisciplinary review of UM data⁷

³ VHA Directive 1190.

⁴ VHA Directive 1190.

⁵ VHA Directive 1190.

⁶ VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019. (This directive was rescinded and replaced with VHA Directive 1117, *Utilization Management Program*, October 8, 2020.) UM reviews include evaluating the “appropriateness, medical necessity and the efficiency of health care services, according to evidence-based criteria.”

⁷ VHA Directive 1117(2). At the time of the facility-level CHIP reviews, VHA Directive 1117(2) required that an interdisciplinary group review UM data on an ongoing basis. This group was to include, but not be limited to, “representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [Chief Business Office Revenue-Utilization Review].” During the fiscal year 2020 review period, the OIG noted multiple opportunities to improve representative attendance. The noted opportunities were repeat findings from the OIG’s 2018 and 2019 evaluations. However, VHA subsequently issued VHA Directive 1117, *Utilization Management Program*, October 8, 2020. VHA Directive 1117 changed the requirement for the review of UM data to be completed by “a multidisciplinary committee,” which may include representatives from “various services.”

- Implementation and monitoring of improvement actions recommended by the interdisciplinary UM group

Finally, the OIG reviewers assessed facilities' reports of patient safety incidents with related root cause analyses (RCAs).⁸ Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout facilities.⁹ The OIG assessed the facilities for their performance on several dimensions:

- Annual completion of a minimum of eight RCAs¹⁰
- Inclusion of required content in RCAs
- Submission of completed RCAs to the National Center for Patient Safety within 45 days
- Provision of feedback about RCA actions to reporting employees
- Submission of an annual patient safety report to facility leaders

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents.¹¹

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG reviews.¹² The findings in this report may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

⁸ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. An RCA is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

⁹ VHA Handbook 1050.01.

¹⁰ VHA Handbook 1050.01. "The requirement for a total of eight RCAs [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the SAC [Safety Assessment Code] score assigned to them...At least four analysis per fiscal year must be individual RCAs, with the balance being Aggregated Reviews or additional individual RCAs."

¹¹ For CHIP site visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

¹² Fiscal year 2020 began October 1, 2019, and ended September 30, 2020.

Methodology

To determine whether VHA facilities implemented and incorporated selected key quality and safety processes into local activities, the OIG evaluated committees responsible for QSV oversight functions; their ability to review data, information, and risk intelligence; and their ability to ensure that key QSV functions are discussed and integrated on a regular basis. The OIG also assessed processes for conducting protected peer reviews of clinical care, UM programs, and patient safety incident reports with related RCAs. Additionally, the OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents.

The OIG performed this review in conjunction with 36 comprehensive healthcare inspections of VHA medical facilities conducted during fiscal year 2020. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks.

The OIG generated individual CHIP reports for each facility. For this report, the OIG analyzed the data from the individual facility reviews to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA completes corrective actions. The comments and action plans submitted by the Acting Under Secretary for Health in response to the report recommendations appear within the report.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.¹³ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

¹³ Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

VHA’s goal is to serve as the nation’s leader in delivering high-quality, safe, reliable, and veteran-centered care.¹⁴ To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.¹⁵ Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission (TJC)), and federal regulations. VHA strives to provide healthcare services that compare “favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency.”¹⁶

Findings and Recommendations

The OIG found general compliance with many of the selected requirements. However, across the facilities inspected in fiscal year 2020, the OIG identified weaknesses in various key quality, safety, and value (QSV) functions:

- Implementation of improvement actions recommended by the committee responsible for QSV oversight
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all suicide deaths that occur within seven days after discharge from an inpatient mental health unit
- Quarterly review of the peer review committee’s summary analysis by the executive-level medical committee
- Documentation of at least 75 percent of physician UM advisors’ decisions in the National UM Integration database
- Inclusion of required processes in RCAs
- Implementation and monitoring of approved improvement actions resulting from RCAs

TJC standards state that facilities are to establish a governing body to provide oversight and support for quality and safety processes.¹⁷ TJC standards also state that facilities should measure and analyze performance using data so that improvement “effectiveness can be sustained, assessed, and measured.”¹⁸ The OIG reviewed meeting minutes for the committees responsible

¹⁴ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

¹⁵ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

¹⁶ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

¹⁷ TJC. Leadership standard rationales LD.01.01.01 and LD.01.03.01.

¹⁸ TJC. Leadership standard rationales LD.03.02.01 and LD.03.05.01.

for QSV oversight functions and found that 29 of the 34 committees had identified improvement actions in response to problems or opportunities for improvement, for which 4 of the 29 committees' action items remained in progress.¹⁹ For 8 of the remaining 25 committees (32 percent), the OIG did not find evidence that closed action items had been fully implemented. This may have resulted in missed opportunities to improve quality of care and patient safety processes. Reasons for noncompliance included lack of oversight and managers' beliefs that facility efforts met the requirements.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facilities fully implement action items recommended by the committees responsible for quality, safety, and value oversight functions.

VHA concurred.

Target date for completion: April 2022

VHA response: VHA's Office of Quality and Patient Safety will establish expectations that facilities implement action items recommended by the committees responsible for quality, safety, and value oversight functions.

OIG comment: The action plan above lacks specific detail. The OIG will monitor implementation during the follow-up process until identified deficiencies are resolved.

VHA requires that facilities complete peer reviews for all applicable deaths within 24 hours of admission.²⁰ The OIG noted that 6 of 24 (25 percent) facilities had not peer reviewed all applicable deaths occurring during the initial 24 hours after admission. Failure to peer review all applicable deaths that occur within 24 hours of admission is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.²¹ However, the OIG closed the associated recommendation on June 3, 2021. The OIG made no further recommendation.

Additionally, VHA requires that facilities complete peer reviews for all suicides that occur within seven days after discharge from an inpatient mental health or residential care facility.²²

¹⁹ One committee did not review aggregated data (Atlanta VA Health Care System in Decatur, GA) and one committee did not identify any improvement actions (Carl Vinson VA Medical Center in Dublin, GA); therefore, the two facilities were not included in this review element.

²⁰ VHA Directive 1190 *Peer Review for Quality Management*, November 21, 2018.

²¹ VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, Report No. 20-01994-18, November 24, 2020.

²² VHA Directive 1190.

The OIG noted that 15 of the 36 facilities had completed suicides during this timeframe after discharge, and 2 of these 15 facilities (13 percent) did not complete peer reviews on those veteran suicides. This resulted in missed opportunities to identify and address potential improvement needs for clinical practice and organizational performance. Some facility managers reported lack of attention to detail and lack of oversight as reasons for noncompliance.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that facilities peer review all applicable suicides.

VHA concurred.

Target date for completion: December 2021

VHA response: VHA's Office of Quality and Patient Safety will establish a plan to ensure that facilities peer review applicable suicides.

OIG comment: The action plan above lacks specific detail. The OIG will monitor implementation during the follow-up process until identified deficiencies are resolved.

VHA requires that a summary of the peer review committee's work be reviewed quarterly by an executive-level medical committee.²³ The OIG found that 6 of 36 facilities' peer review committees (17 percent) did not consistently provide summaries of work for executive-level medical committees to review. Failure to submit aggregate data to leadership for analysis could affect improvements in patient care at noncompliant facilities. Reported reasons for noncompliance included general lack of oversight and staffing issues.

The lack of executive-level medical committees' quarterly review of peer review committees' summaries is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*. Improvement actions from the fiscal year 2019 report remain in progress. The OIG made no further recommendation.²⁴

VHA requires physician UM advisors to document decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays for at

²³ VHA Directive 1190.

²⁴ VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*.

least 75 percent of all required inpatient stays.²⁵ The OIG found that 5 of 35 applicable facilities (14 percent) did not complete 75 percent of all UM required reviews.²⁶ This resulted in an inadequate level of evaluations for the appropriateness of admissions and continued stays and may have contributed to missed performance improvement opportunities. Reasons for noncompliance included staffing issues and lack of oversight.

The lack of documentation of physician UM advisors' decisions in the National UM Integration database is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018* and *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*. However, the OIG closed the associated recommendation on March 22, 2021, based on the evidence of improvement provided by VHA.²⁷ The OIG made no further recommendation.

For RCAs, VHA requires the analyses to include several elements, such as determination of human factors, the processes and systems related to the occurrence, and analysis of the underlying systems to help identify and mitigate vulnerabilities and avoid future occurrences.²⁸ VHA also requires the implementation and monitoring of recommended improvement actions resulting from RCAs.²⁹ The OIG reviewed 178 RCAs performed at the 36 facilities and found that 31 (17 percent) did not include an analysis of the underlying systems to determine where system redesigns might reduce risk. The OIG also found that action items were not fully implemented in 27 of 154 (18 percent) applicable RCAs, and outcome measures did not show sustained improvement in 14 of 84 (17 percent) applicable RCAs. These issues likely limited reviewers' ability to identify vulnerabilities and resulted in inadequate implementation of process improvements that could help prevent patient harm events. Reasons for noncompliance included managers' beliefs that facility efforts met the requirements, staffing issues, and lack of attention to detail.

²⁵ VHA Directive 1117(2) *Utilization Management Program*, July 9, 2014, amended April 30, 2019, was rescinded on October 8, 2020, and replaced with VHA Directive 1117 *Utilization Management Program*. The two documents contain similar language for physician UM advisors to document decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays for at least 75 percent of all required inpatient stays. VHA Directive 1117 also allows for physician UM advisors to document decisions in the electronic health record regarding appropriateness of patient admissions and continued stays.

²⁶ This review element did not apply to the Tuscaloosa VA Medical Center, which does not have acute inpatient beds.

²⁷ VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, Report No. 20-01994-18, November 24, 2020; VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report No. 19-07040-243, October 10, 2019; *VHA Status Request—Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report Number 19-07040-243, October 10, 2019, received March 22, 2021.

²⁸ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

²⁹ VHA Handbook 1050.01.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that root cause analyses include a review of the underlying systems to determine where system redesigns might reduce risk.

VHA concurred.

Target date for completion: July 2022

VHA response: VHA's Office of Quality and Patient Safety and the National Center for Patient Safety will establish a plan to ensure that root cause analyses include a review of the underlying systems to determine where systems redesigns might reduce risk.

OIG comment: The action plan above lacks specific detail. The OIG will monitor implementation during the follow-up process until identified deficiencies are resolved.

Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facilities fully implement approved root cause analysis action items and outcome measures show sustained improvement.

VHA concurred.

Target date for completion: July 2022

VHA response: VHA's Office of Quality and Patient Safety and the National Center for Patient Safety will establish a process to ensure that facilities fully implement approved root cause analysis action items and that outcome measures show sustained improvement.

OIG comment: The action plan above lacks specific detail. The OIG will monitor implementation during the follow-up process until identified deficiencies are resolved.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The intent is for VHA leaders to use these 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	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality Safety and Value	<ul style="list-style-type: none"> • QSV committee • Protected peer reviews • UM reviews • Patient safety 	<ul style="list-style-type: none"> • Facilities fully implement action items recommended by the committees responsible for QSV oversight functions. • Facilities peer review all applicable suicides. • RCAs include a review of the underlying systems to determine where system redesigns might reduce risk. • Facilities fully implement approved RCA action items and outcome measures show sustained improvement. 	<ul style="list-style-type: none"> • None

Appendix B: Parent Facilities Inspected

**Table B.1. Parent Facilities Inspected
(October 1, 2019, through September 30, 2020)**

Names	City
Ann Arbor VA Medical Center	Ann Arbor, MI
Charlie Norwood VA Medical Center	Augusta, GA
Battle Creek VA Medical Center	Battle Creek, MI
Birmingham VA Medical Center	Birmingham, AL
Boise VA Medical Center	Boise, ID
Ralph H. Johnson VA Medical Center	Charleston, SC
Jesse Brown VA Medical Center	Chicago, IL
Chillicothe VA Medical Center	Chillicothe, OH
Cincinnati VA Medical Center	Cincinnati, OH
Harry S. Truman Memorial Veterans' Hospital	Columbia, MO
Columbia VA Health Care System	Columbia, SC
VA Illiana Health Care System	Danville, IL
Dayton VA Medical Center	Dayton, OH
Atlanta VA Health Care System	Decatur, GA
John D. Dingell VA Medical Center	Detroit, MI
Carl Vinson VA Medical Center	Dublin, GA
Edward Hines Jr. VA Hospital	Hines, IL
Oscar G. Johnson VA Medical Center	Iron Mountain, MI
Kansas City VA Medical Center	Kansas City, MO
William S. Middleton Memorial Veterans Hospital	Madison, WI
Marion VA Medical Center	Marion, IL
VA Northern Indiana Health Care System	Marion, IN
Clement J. Zablocki VA Medical Center	Milwaukee, WI
Central Alabama Veterans Health Care System	Montgomery, AL
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
John J. Pershing VA Medical Center	Poplar Bluff, MO
VA Portland Health Care System	Portland, OR
VA Roseburg Health Care System	Roseburg, OR
Aleda E. Lutz VA Medical Center	Saginaw, MI
VA Puget Sound Health Care System	Seattle, WA

Names	City
Mann-Grandstaff VA Medical Center	Spokane, WA
VA St. Louis Health Care System	St. Louis, MO
Tomah VA Medical Center	Tomah, WI
VA Eastern Kansas Health Care System	Topeka, KS
Tuscaloosa VA Medical Center	Tuscaloosa, AL
Robert J. Dole VA Medical Center	Wichita, KS

Source: VA OIG.

Appendix C: Office of the Deputy to the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: August 4, 2021

From: Deputy to the Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2020 (2021-01502-HI-1147) (VIEWS #05617102)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) subject draft report. The Veterans Health Administration concurs with the recommendations and provides the attached action plan.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven Lieberman, M.D.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Inspection Team	Jennifer Frisch, MSN, RN, Project Leader Keri Burgy, RN, MSN Tasha Felton-Williams, DNP, ACNP Janice Fleming, DNP, RN Rose Griggs, MSW, LCSW Rowena Jumamoy, MSN, RN Sheeba Kenneth, MSN, CNL, RN-BC Debra Naranjo, DNP, RN Jennifer Reed, RN, MSHI Elizabeth Whidden, MS, ARNP Michelle Wilt, MBA, BSN
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Other Contributors	Elizabeth Bullock Ashley Fahle Gonzalez, MPH LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Scott McGrath, BS Larry Ross, Jr., MS Krista Stephenson, MSN, RN Robyn Stober, JD, MBA Caitlin Sweany-Mendez, MPH, BS
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