Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 1038
Transmittal Sheet
August 2, 2017

ROLE OF THE OFFICE OF THE MEDICAL INSPECTOR

1. REASON FOR ISSUE: This VHA directive assigns responsibilities to the Office of the Medical Inspector (10E1B).

2. SUMMARY OF CONTENT: This VHA directive sets forth policy on two different aspects of the responsibilities of the Office of the Medical Inspector and the responsibilities of VA and VHA Program Offices and facilities in regard to Office of the Medical Inspector reports and assigns the full force of the Under Secretary for Health to the investigations of the Office.

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: The Office of the Medical Inspector (10E1B) is responsible for the content of this directive. Questions may be addressed to Lawrence Papier at 202-443-5084.

5. RESCISSIONS: VHA Directives 2011-002, dated January 27, 2011 and 2011-031, dated August 2, 2011, are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of August 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Acting Under Secretary for Health

DISTRIBUTION: Emailed to the VHA Publications Distribution List on August 3, 2017.

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1. PURPOSE

This Veterans Health Administration (VHA) directive outlines the role of the Office of the Medical Inspector (OMI), and the roles of other VHA offices, including the Under Secretary for Health, Deputy Under Secretary for Health for Organizational Excellence, the Deputy Under Secretary for Health for Operations and Management, VHA Program Office leadership, Veterans Integrated Service Network (VISN) Directors, and Department of Veterans Affairs (VA) medical facility Directors, in quality of care investigations, along with responsibilities for preparing, reviewing, approving, and releasing OMI reports. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. In 1980, VA established OMI to assess and report on quality of care issues within VHA directly to the Under Secretary for Health. With Public Law 100-322, "Veterans Benefits and Services Act of 1988," Congress expanded the functions of OMI and assigned the VA Office of the Inspector General (OIG) an oversight role. This law addressed the Department's quality assurance activities, upgraded and expanded OMI, and increased its number of employees to ensure its independence, objectivity, and accountability.

b. In 2014, OMI underwent restructuring, in which its telephone triage function was transferred to the OIG hotline and its oversight role was enhanced by a September Under Secretary for Health memorandum reinforcing OMI’s status as an independent, objective advisor to the Under Secretary for Health and charging OMI with resuming investigations into whistleblower allegations.

c. Also in 2014, the Under Secretary for Health set up a new division headed by the Deputy Under Secretary for Health for Organizational Excellence and an Assistant Deputy Under Secretary for Health for Integrity that included OMI, the Office of Compliance & Business Integrity, the Management Review Service, the National Center for Ethics in Health Care (NCEHC), and the Internal Audits & Risk Assessment Office. In this setting, OMI performs major investigations only, most of which involve one or more site visits, as assigned by the Under Secretary for Health through the Deputy Under Secretary for Health for Organizational Excellence and the Assistant Deputy Under Secretary for Health for Integrity. The information and data gathered through OMI investigations are used to inform and improve VHA’s health care delivery.

d. The timely generation of a final report requires contributions from multiple organizations in VA Central Office, including the Office of General Counsel (OGC), the Office of Accountability Review (OAR), the NCEHC, VHA program offices, VISNs, and VA facilities. Each report contains background, findings, conclusions, recommendations, and attachments, generally of source material. The processes and responsibilities that follow apply to all OMI investigations and reports.

3. POLICY

It is VHA policy that the OMI must investigate the quality of VA health care and report its findings from investigations. VHA officials and staff must cooperate with OMI, and requests for information or follow up by OMI are to be viewed as requests by the Under Secretary for Health. Although OMI functions independently, with oversight by the OIG, it cannot function without the full cooperation of VHA program offices and field facilities.

4. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for:

(1) Assigning all investigations to OMI by directing Executive Correspondence (10B1) to charge OMI with a new investigation.

(2) Approving and signing Internal Reviews and accompanying acceptance memos to the Deputy Under Secretary for Health for Operations and Management and Deputy Under Secretary for Health for Organizational Excellence.

(3) Approving and signing Blue Cover Reports and accompanying acceptance memos to the Deputy Under Secretary for Health for Operations and Management and Deputy Under Secretary for Health for Organizational Excellence, cover letters to the chairs of HVAC and SVAC, and 0907 briefing sheet for the Secretary.

(4) Approving (not signing) OSC Reports, cover letters from the Secretary to the Special Counsel, and 0907 briefing sheets for the Secretary.

(5) Accepting OMI's notification of completion of Action Plans in response to report recommendations and subsequently notifying the Deputy Under Secretary for Health for Operations and Management and Deputy Under Secretary for Health for Organizational Excellence of completion.

b. **Deputy Under Secretary for Health for Organizational Excellence.** The Deputy Under Secretary for Health for Organizational Excellence is responsible for:

(1) Reviewing and providing comments on draft reports.

(2) Providing a representative to participate in a Review Panel (comprised of experts from VA and VHA program offices) for the purpose of discussing draft reports and providing comments and edits to said reports.

(3) Submitting additional corrections on draft reports following Review Panel.

(4) Concurring on final draft report and transmittals.

(5) Distributing the final report to the relevant VHA Program Office(s) for corrective Action Plan(s).

(6) Coordinating VHA Program Office(s) corrective actions in response to report recommendations.

c. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Reviewing and commenting on draft reports; distributing these reports to the VISN and VA health facility that is the subject of an OMI investigation, and requesting comments within five business days.

(2) Attending Review Panel meetings to present comments on draft reports.

(3) Submitting any additional corrections to draft reports following Review Panel.

(4) Concurring on final draft reports and transmittals.

(5) Distributing the signed report to the VISN and the VA health facility that is the subject of an OMI investigation, requesting a corrective Action Plan in response to report recommendations within 14 calendar days of receipt of report.

d. **Office of the Medical Inspector.** OMI is responsible for:

(1) Assembling and leading VA teams of OMI clinicians, VHA Human Resources (HR) specialists, subject matter experts (SME) from VHA program offices or field facilities. If there is involvement by Senior Executive Service (SES), SES EQV, and non-SES members of facility executive leadership teams (commonly referred to as the "quadrad" or "pentad"), HR specialists from OAR will augment VA teams by participating in on-site reviews, interviews, documentation of findings, and preparation of reports.

(2) Following a site visit, briefing the Under Secretary for Health and other senior VHA leaders on preliminary findings and recommendations.

(3) Preparing a draft report containing the investigative team's findings, conclusions, and recommendations. Upon completion, distributing the draft report for review and comment to appropriate VA and VHA program offices, including OGC, OAR, NCEHC, the Deputy Under Secretary for Health for Organizational Excellence, and the Deputy Under Secretary for Health for Operations and Management. The latter will send draft reports to the facility under investigation and to their VISN(s) for review and comment.

(4) Convening a Review Panel to discuss a draft report, and to obtain comments/edits, and informal concurrence.

(5) Revising the draft report as necessary according to input received from the Review Panel.

(6) Incorporating final changes in a revised draft of the report and entering it, along with transmittal documents, into VAIQ for formal concurrence from the following offices: OGC, OAR, Deputy Under Secretary for Health for Operations and Management and Assistant Deputy Under Secretary for Health for Clinical Operations.

(7) Upon receiving concurrences from the above offices, preparing an official hard-copy folder consisting of the final report, transmittal documents, and evidence of concurrence for final review by the Assistant Deputy Under Secretary for Health for Integrity and the Deputy Under Secretary for Health for Organizational Excellence. Following their review, submit approved folder to 10B1.

(8) Distributing approved report to the Deputy Under Secretary for Health for Operations and Management and the Deputy Under Secretary for Health for Organizational Excellence, respectively, for VA facility and VHA Program Office(s) corrective Action Plans.

(9) Submitting a closure package to the Under Secretary for Health when VA facilities and VHA Program Offices have completed their Action Plans in response to report recommendations. In the case of an OSC investigation, this package will be prepared after OSC has notified VA in writing that the investigation is closed. The closure package consists of:

(a) A transmittal memorandum recommending closure of the investigations;

(b) An acceptance memo from the Under Secretary for Health to the Deputy Under Secretary for Health for Operations and Management and/or the Deputy Under Secretary for Health for Organizational Excellence declaring the investigation closed.

e. **Executive Correspondence.** 10B1 is responsible for:

(1) Entering an assignment in VAIQ notifying OMI that the Under Secretary for Health has charged the office with conducting a new investigation.

(2) Conducting a final review of the folder before submitting it to the Under Secretary for Health for approval and/or signature.

(3) Notifying OMI when a report has been signed by the Secretary or the Under Secretary for Health.

(4) Forwarding the report to the Freedom of Information Act (FOIA) Office for redactions

f. **Program Office, VISN, or VA Medical Facility.** Program office leadership, VISN Directors, or VA medical facility Directors are responsible for:

(1) Ensuring requests for information from OMI (whether oral or in writing), are promptly and completely answered. OMI, as a component of VHA, has legal

authority under applicable Federal privacy laws and regulations to access and use any information, including health information, maintained in VHA records for the purposes of health care operations and health care oversight. OMI's requests for information must be honored. If any problems in responding are anticipated, OMI is to be contacted immediately to review issues and to determine how they will be handled. OMI's decision in this regard is final.

(2) Providing, when requested, SMEs to augment the skills of the VA teams OMI has assembled to conduct investigations.

(3) Making SMEs available to review draft reports and to participate in Panel Review.

(4) Cooperating fully with the investigation. Maximum support and assistance is provided to an OMI team in the course of an investigation. Should the effort required to respond promptly to an OMI request impinge on a unit's ability to do its work in a timely manner, the unit, through the program office and facility Director, may request an extension for replying, and:

(a) Submitting comments to the Deputy Under Secretary for Health for Operations and Management within 5 business days of receiving a draft report,

(b) Submitting an Action Plan addressing corrective actions to the Deputy Under Secretary for Health for Operations and Management within 14 calendar days of receiving a final report,

(c) Implement corrective actions until all are completed and verified by OMI and the Deputy Under Secretary for Health for Operations and Management,

(d) Ensuring, when issues arise that might lead to questions or difficulties regarding provision of information to or support for the OMI team, that the Medical Inspector is contacted directly.

g. **Freedom of Information Act Office.** The VHA FOIA Office redacts final reports signed by the Under Secretary for Health or the Secretary and must respond to FOIA requests for OMI reports from individuals and organizations outside VA.

h. **VA Office of Congressional and Legislative Affairs.** For Blue Cover Reports only, the VA Office of Government Relations is responsible for:

(1) Reviewing and concurring on transmittal letters from the Secretary to the Chairs of the Senate and House Committees on Veterans' Affairs; and

(2) Providing unredacted Blue Cover Reports to the Chairs of the Senate and House Committees on Veterans Affairs, and redacted copies of reports to other members of Congress upon request.

5. SOURCES OF OMI INVESTIGATIONS

a. **Under Secretary for Health.** When the Under Secretary for Health has identified concerns at a VA medical facility, a VISN, or a VHA program office, they direct OMI to address the matter and recommend actions to resolve the problems. OMI assembles and leads an investigative team for either a site visit or a record review to get the facts. These investigations generate Internal Reviews approved and signed by the Under Secretary for Health and circulated to designated persons or offices within VHA.

b. **Secretary of Veterans Affairs.** The Secretary of Veterans Affairs receives requests from members of Congress, acting on behalf of constituents, Veterans Service Organizations, or in response to media reports of problems at VA medical facilities. The Secretary charges the Under Secretary for Health to direct the OMI to assemble and lead a VA team to investigate the allegations. OMI then writes a Blue Cover Report and responds to Congressional queries for follow-up actions.

c. **Office of Special Counsel.** OSC refers whistleblower allegations regarding the VA to the Secretary, who assigns them to the appropriate VA administration for investigation. Within VHA, the Under Secretary for Health typically directs OMI to assemble and lead a VA team to investigate the allegations. OMI then oversees the writing of a report and responds to OSC's queries for follow-up actions. Privacy and quality assurance disclosure laws apply to all OMI reports.

6. REFERENCES

a. Title 38 United States Code (U.S.C.) 7301(b).

b. Public Law 100-322, Veterans Benefits and Services Act of 1988.