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Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan

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Executive Summary

In response to a congressional request from Senators Gary Peters and Debbie Stabenow, and Representatives Debbie Dingell and Rashida Tlaib, the VA Office of Inspector General (OIG) conducted an inspection of the John D. Dingell VA Medical Center (facility) in Detroit, Michigan, to assess leaders' progress toward implementation of recommendations made in a Veterans Health Administration (VHA) Office of the Medical Inspector (OMI) report.[1] The OIG evaluated Veterans Integrated Service Network (VISN) 10 leaders' oversight of, and support provided to, facility leaders.

During the inspection, the OIG identified concerns surrounding past facility leaders' failure to incorporate High Reliability Organization (HRO) practices, including bi-directional communication, governance and policy management, and promoting a psychologically safe environment.[2]

In November 2021, the OMI investigated allegations regarding surgical quality of care, to include a review of care rendered by the former chief of surgery, at the facility.[3] In April 2022, the OMI issued inspection findings that resulted in 10 recommendations regarding provider oversight, surgical services, and quality reviews.[4]

[1] VHA Directive 1038, *Role of the Office of the Medical Inspector*, August 2, 2017. Established in 1980, the OMI reports directly to the Under Secretary for Health. The OMI assesses and reports on health care issues raised by veterans and other stakeholders to improve the quality of VA health care. While the OMI functions independently within VHA, the OIG provides oversight of OMI activities. "VHA Office of the Medical Inspector" (web page), Veterans Health Administration, accessed January 31, 2023, https://www.va.gov/health/medicalinspector.

[2] VA, VHA, "VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only," September 2022. "High reliability means evidence-based, high-quality care is consistently delivered for every patient, every time, at any facility across VHA." VHA began implementing HRO practices in 2018 and was implementing HRO enterprise-wide as of September 2022. "VHA's Journey to High Reliability is a long-term commitment to our Veterans and our workforce to continuously improve and advance toward Zero Harm. . . [supporting] our efforts to regain the trust of Veterans."

[3] In August 2021, the Facility Director summarily suspended the former chief of surgery's clinical privileges. The interim Chief of Staff (COS) told the OIG that the former chief of surgery had not performed any surgeries at the facility since August 2021. The interim COS permanently reassigned the former chief of surgery to a general surgeon position in January 2022. The former chief of surgery was removed from employment at the facility in April 2023. The OMI recommendations did not address state licensing board reporting.

[4] *Report to the Under Secretary for Health, John D. Dingell Veterans Affairs Medical Center, Detroit, Michigan*, TRIM 2021-C-51, April 16, 2022. The 2022 OMI report resulted in 12 recommendations; however, the OIG evaluated 10 of the OMI recommendations, as the remaining two recommendations pertained to administrative issues outside of the scope of this review.

The OIG found concerns related to VISN and facility leaders' corrective actions in response to 6 of the 10 OMI recommendations.[5] The OIG identified three additional concerns related to instability in facility leadership, the impact of leaders' actions on HRO principles, and VISN oversight of, and support to, facility leaders.

OIG Findings

OMI Recommendation: Review requirements for supervision of residents from VHA Directive 1400.01, Supervision of Physicians, Dental, Optometry, Chiropractic and Podiatry Residents, dated November 7, 2019, with supervising physicians in surgery.

While the OIG determined that facility leaders' corrective actions were responsive to the recommendation, the OIG also noted a gap regarding supervision of post-graduate year one (PGY-1) general surgery residents while on-call overnight at the facility. The OIG found facility on-call PGY-1 general surgery residents were not supervised per VHA requirements.[6] VHA requires that PGY-1 residents "have on-site supervision at all times by either a supervising practitioner or a more advanced resident, with the supervising practitioner being available on-call."[7] A general surgeon and a general surgery resident told the OIG that PGY-1 general surgery residents provided overnight coverage without direct supervision. The OIG considered the lack of direct supervision of PGY-1 general surgery residents a significant patient safety risk as PGY-1 residents may not have the experience required to provide competent and independent patient care.

Due to patient safety concerns, the OIG shared this finding with facility and VISN leaders during the site visit exit briefing. Facility leaders reported unawareness of the PGY-1 supervision requirement and discussed options for compliance immediately after the briefing. Following the OIG site visit, the interim Chief of Staff (COS) told the OIG the facility had begun corrective actions, which included a temporary plan of having an attending, or a more advanced resident,

[5] The OMI provided the OIG with three action plans used to communicate the status of corrective actions taken to address the OMI's recommendations and document the status of the recommendation (i.e. open or closed). The action plans included narrative comments and documents embedded by the facility that were used as evidence to close recommendations. The OIG review of documentation included both embedded documents and narrative statements provided by facility and VISN leaders. The OIG did not independently validate the OMI's review and findings. The OIG did not identify concerns with the facility leaders' response to four OMI recommendations related to (1) hiring fee-based providers to ensure adequate safe surgical coverage, (2) privileging of on-call providers, (3) documenting Peer Review Committee discussions, and (4) consulting with VHA Clinical Risk Management regarding peer review and quality processes.

[6] VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. A PGY-1 resident, also known as an "intern," is a health professional trainee in a graduate training program and in the first year of post-graduate clinical training.

[7] VHA Directive 1400.01.

on-site overnight to provide direct supervision to PGY-1 general surgery residents through the month of December 2022, with a revised and compliant resident on-call model to start in 2023.[8]

Subsequently, the VISN chief surgical consultant (VCSC) reviewed the models of PGY-1 general surgery resident supervision across the VISN and identified one additional facility in the VISN that was not meeting the PGY-1 resident supervision requirement. In January 2023, the facility implemented a revised model compliant with direct supervision requirements.

While the OIG found facility leaders did not meet VHA requirements related to the supervision of PGY-1 general surgery residents, VISN and facility leaders took immediate steps to ensure compliance across the VISN.[9]

OMI Recommendation: Request consultation by NSO for the entire surgery program including review of the Chief of Surgery's cases for the last 2 years.

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation, including the results of a retrospective case review of 410 cases, which reportedly represented 100 percent of cases performed by the former chief of surgery from May 2020 through August 2021. In January 2023, the OMI closed the recommendation based on completion of the retrospective review and the pending issuance of a report related to the National Surgery Office (NSO) surgical program consultation.[10] In March 2023, the NSO issued a memorandum documenting a program review of the facility surgery service. The memorandum included recommendations related to oversight, leadership support and communication, and peer review. The NSO also recommended facility leaders develop "a strategic plan for the surgery service to include surgical safety, quality, access, [and] operational efficiency."[11] The OIG identified the need for facility leaders to ensure a comprehensive and sustainable response to the recommendations noted in the NSO memorandum.[12]

[8] VHA Directive 1400.01. An *attending* is a senior physician who serves as a supervisor to residents who are in advanced medical training. For the purposes of this report, a more advanced resident is any resident PGY-2 or later in training.

[9] VHA Directive 1400.01.

[10] The OIG interviewed the OMI inspection team who stated that they closed the recommendation in January 2023 as they were aware of the results in the pending NSO report and believed the report met the intent of the OMI recommendation.

[11] NSO National Director of Surgery, "Program Review, John D. Dingell VA Medical Center Surgery Program," memorandum to the Acting Director, John D. Dingell VA Medical Center, March 20, 2023.

[12] On April 6, 2023, the interim chief of quality, safety, and value provided the OIG with an action plan developed in response to the NSO review.

Review of External Reporting

Upon review of facility leaders' response to the OMI's recommendation regarding National Practitioner Data Bank (NPDB) reporting, the OIG identified additional concerns regarding the delay of a proposed privileging action and missed opportunities for State Licensing Board (SLB) reporting regarding the former chief of surgery. VHA requires external reporting of certain malpractice payments and clinical privileging actions for VA practitioners to the NPDB and SLB.[13]

OMI Recommendation: Notify NPDB, if not already addressed, regarding malpractice and privileging suspension per VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, dated December 28, 2009.

One purpose of external reporting, when appropriate, is to prevent providers from being able to move to different employment without disclosure of incompetent performance.[14] VHA requires facility directors to report healthcare providers to the NPDB if either of the following are applicable: payments made because of a settlement or judgment of a claim of malpractice, or if there are final adverse clinical privilege actions in effect for longer than 30 days.[15]

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation. The documentation included a decision made by interim Facility Director 2 to pursue revocation of the former chief of surgery's clinical privileges.

Upon review, the OIG identified an additional concern with the corrective actions taken that led to the closure of this recommendation in January 2023. Specifically, there was a delay in processing a recommendation to revoke the former chief of surgery's clinical privileges that would lead to NPDB reporting.

OIG-Identified Concern Regarding Delay in Privilege Revocation

As a result of concerns raised regarding those aspects of the former chief of surgery's clinical practice that "[did] not meet accepted standards and potentially constitute an imminent threat to patient safety," the interim COS recommended the suspension of the former chief of surgery's clinical privileges. Subsequently, the Facility Director summarily suspended the former chief of

[13] VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, December 28, 2009.

[14] *"National Practitioner Data Bank, About Us" (web page),* US Department of Health and Human Services, accessed March 6, 2023, https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp.

[15] VHA Handbook 1100.17. The handbook further notes that examples of adverse clinical privilege actions include restriction, suspension, and revocation. Summary suspension of clinical privileges is not reportable until an adverse final action is made by the facility director.

surgery's clinical privileges as of June 13, 2022.[16] The Clinical Executive Committee held a meeting in October 2022 and discussed the completed VISN review of 60 cases performed by the former chief of surgery and voted to recommend reinstating the former chief of surgery's clinical privileges. Interim Facility Director 1 reported nonconcurrence with the Clinical Executive Committee's decision and, on November 28, 2022, recommended the revocation of clinical privileges for the former chief of surgery. On February 27, 2023, after the OIG's third request for an update on the status of the former chief of surgery's clinical privileges, a VISN representative provided evidence that the Clinical Executive Committee met again on January 23, 2023, discussed the NSO's review, and voted to recommend the revocation of the former chief of surgery's clinical privileges. A VISN representative informed the OIG that the interim Facility Director 2 concurred with the Clinical Executive Committee's recommendation and forwarded the revocation memorandum to human resources.

When asked about the outcome of the initial revocation recommendation made in November 2022, a VISN representative stated that, "due to the complexity of the case, multiple investigations, and the discordance between the [Clinical Executive Committee] and [interim] Director recommendations, it [took] an extended length of time to draft this letter."

While the OIG acknowledges that it takes time to carefully review clinical activities, the OIG opined that the two-month processing delay on a final adverse clinical privilege action, reportable to the NPDB, undermined the intent of NPDB reporting. The processing delay is also an example of siloed communication and reflects the need for additional VISN oversight, intervention, and support.

OIG-Identified Concern Regarding State Licensing Board Reporting

During a review of facility leaders' response to the NPDB recommendation, the OIG identified an additional concern regarding SLB reporting. The OIG found that in two clinical reviews of the former chief of surgery's care, performed prior to this inspection, VHA reviewers identified 16 episodes of substandard care that met the requirements to initiate the SLB reporting process in the state(s) in which the former chief of surgery was actively licensed.

VHA has broad authority to report providers to SLBs "when substantial evidence supports a reasonable conclusion that the professional's clinical practice during VA employment so

[16] The Facility Director began a detail to a position in VA Central Office in July 2022. The report also identifies interim Facility Director 1 (July 5, 2022, through December 31, 2022) and interim Facility Director 2, who assumed the role on January 1, 2023.

significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients or the community."[17]

Per VHA policy, facility directors have ultimate decision authority to determine whether clinical care provided by a VA provider failed to meet generally accepted standards of clinical practice to the extent that a safety concern is raised. In such cases, SLB reporting must be initiated immediately.[18]

The OIG analyzed the following quality reviews of cases performed by the former chief of surgery:

- a VISN review of surgical cases noted in the OMI report as a response to a request from the VA Office of the Secretary due to the former chief of surgery's high complication rate. Per the VCSC's final report of the VISN review, 24 of the 54 cases were sent for further national review (August 2021); and
- a VISN review of 60 surgical cases performed as follow-up to a summary suspension of privileges (June 2022).

In the August 2021 national review of 24 cases, 6 cases involved standard of care concerns regarding pre-operative, peri-operative, and post-operative patient care management.

Upon receipt of the national review, the COS emailed the Facility Director and stated, "we really have no other reasonable choice at this point but to go above this and remove [the former chief of surgery] from clinical activity based on a continuous threat to patient safety."

In June 2022, the VISN initiated a review in response to the interim COS's concerns that the former chief of surgery's clinical practice did not meet accepted standards and was a potential threat to patient safety. This VISN review identified 10 additional standard of care concerns related to pre-operative, peri-operative, and post-operative patient care management.

A VISN leader and facility leaders told the OIG that, despite multiple findings of failure to meet the standard of care, SLB reporting had not been initiated. The interim Facility Director 1 and interim COS told the OIG that reporting would follow the revocation of the former chief of surgery's privileges and a VISN program manager shared that reporting had not started "because it was still in the investigation stage."

[17] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. Substantial evidence is "the degree of relevant evidence that. . . a reasonable person might accept as adequate to support a conclusion, even if it is possible to draw contrary conclusions from the evidence, for believing that the professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients or the community."

[18] VHA Directive 1100.18.

The OIG found that the 16 cases with standard of care concerns, identified in two clinical reviews conducted prior to this inspection, met the SLB reporting threshold.[19] The OIG concluded that the national and VISN reviews of the former chief of surgery's practice provided evidence that a reasonable person could accept as adequate to support a concern for the safety of facility surgical patients and thus the Facility Director and interim Facility Director 1 each missed an opportunity to initiate the SLB reporting process. The facility was not in compliance with VHA policy by failing to notify the SLB of the identified care concerns in the state(s) in which the former chief of surgery was actively licensed.[20] Based on the two clinical reviews and a third, more recent review reported in February 2023, the OIG identified the need for continued VISN oversight to ensure facility leaders meet SLB reporting requirements.

Review of Quality Management Processes

The OMI made three recommendations regarding quality management activities at the facility. Upon review of facility leaders' response to the recommendations, the OIG identified two additional concerns related to morbidity and mortality (M&M) conferences and the peer review process.

OMI Recommendation: Develop template and conduct M&M meetings on a timely basis in a formal process with appropriate minutes.

Upon review of the facility leaders' response to the recommendation, the OIG found evidence of regular M&M conferences and that associated minutes were templated.[21] However, upon review of the minutes from M&M conferences conducted during the review period, the OIG identified a related concern regarding the interim chief of surgery's facilitation and oversight of M&M conferences. Specifically, the OIG found that the interim chief of surgery inconsistently participated in M&M conferences and instead relied on the surgical quality nurse for planning and facilitating M&M conferences.

VHA requires the chief of surgery and surgical quality nurse to participate in M&M conferences. However, the chief of surgery holds the responsibility for facilitating M&M conferences.[22] When asked, the interim chief of surgery denied facilitating M&M conferences, deferring this task to the surgical quality nurse. Further the surgical quality nurse reported being designated by the

[19] On February 3, 2023, the OIG learned from the interim COS that a third VISN review of the former chief of surgery's cases (273), performed as a result of the OMI recommendation, identified seven cases which did not meet the standard of care.

[20] VHA Directive 1100.18.

[21] VHA Directive 1320, *Quality Management and Patient Safety Activities that can Generate Confidential Records and Documents*, July 10, 2020. M&M are "discussions among clinicians of the care provided to individual patients who died or experienced complications" and are used for improving quality of health care.

[22] VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

previous COS as responsible for ensuring continuation of surgical meetings, such as M&M conferences. VHA policy requires the chief of surgery, even in an interim capacity, to facilitate and provide oversight of M&M conferences.

OMI Recommendation: Develop local procedures/guidelines to establish that a Peer Review Committee Member with a level 3 review should be reassessed by a neutral Peer Review Committee at another facility.

The OIG reviewed documentation facility leaders provided the OMI to close a recommendation made in response to an allegation of facility leaders' manipulation of the peer review process. The OIG found that facility leaders changed the process of review when the provision of care by Peer Review Committee members is reviewed, specifically requiring an initial, neutral party, review each case.[23] However, the OIG noted that the process did not include a neutral party conducting a final review of Peer Review Committee member's cases.

The OIG learned during interviews that the facility leaders changed practice in response to the OMI recommendation to ensure all initial peer reviews for committee members were sent for outside review. The risk manager also provided the OIG with a "Job Instruction Sheet," developed in July 2022. The OIG found the "Job Instruction Sheet" indicated all initial reviews of Peer Review Committee members must be sent for external review but did not address the OMI's recommendation that reviews of Peer Review Committee members with an initial level 3 rating be "reassessed by a neutral Peer Review Committee at another facility."[24]

The OIG is concerned that, although quality management leaders developed a process for external initial reviews of Peer Review Committee members, this corrective action does not ensure the integrity of a final level peer review designation as the Peer Review Committee, not a neutral reviewer, makes the final level determination.

[23] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level. A facility Peer Review Committee is comprised of the Chief of Staff, or designee, key clinical leaders, and other appropriate clinical peers.

[24] VHA Directive 1190. "Level 3 is the level at which experienced and competent clinicians would have managed the case differently."

Facility Leadership Support

OMI Recommendation: The Veterans Integrated Service Network 10 should immediately assist Detroit with general surgical physician and COS leadership support.

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation, and found that the VCSC and Chief Medical Officer (CMO) provided support to the facility's general surgery department and interim COS. However, the OIG identified two additional concerns regarding oversight of the VISN Academic Affiliations Program and VISN surgical workgroup.

OIG-Identified Concern Regarding VISN Academic Affiliations Program Oversight

The OIG identified the VISN academic affiliations officer's lack of oversight and support to ensure compliance with VHA policy.[25] Further, the OIG identified an instance of siloed communication within the VISN as the CMO did not inform the VISN academic affiliations officer of the OMI-identified general surgery residency concerns, nor was the VISN academic affiliations officer aware of any concerns regarding the direct supervision of general surgery residents at the facility.

Per VHA policy, the VISN academic affiliations officer is responsible for ensuring compliance with the medical residency directive as well as maintaining "a robust local monitoring program."[26] Although the VISN academic affiliations officer role is a collateral duty, filled by a physician employed at another VISN 10 facility, the position is responsible for maintaining "awareness and oversight of facility level activities" and "[responding] to allegations of non-compliance." The CMO, who functions as administrative supervisor of the VISN academic affiliations officer, reported intermittently working with the VISN academic affiliations officer, but was unaware of specific position description requirements or collateral duty status related to the position.

The VISN academic affiliations officer reported no awareness of the OMI report or recommendations regarding the facility's general surgery residency program and denied having any involvement with, or oversight of, the residency program at the facility.

The OIG found the VISN academic affiliations officer did not provide proactive oversight of the facility's residency activities or respond to allegations of non-compliance as outlined within the position's memorandum of understanding. Further, the OIG found this position lacked

[25] VHA Directive 1400.01. The VISN 10 academic affiliations lead is referred to as the VISN academic affiliations officer throughout this report.

[26] VHA Directive 1400.01.

substantive oversight as outlined in VHA policy.[27] The OIG expects the CMO to provide oversight to the VISN academic affiliations officer to include ensuring awareness of compliance issues identified at VISN facilities.

OIG-Identified Concern Regarding Oversight by the VISN Surgical Workgroup

The OIG found the VCSC provided additional support to facility surgical leaders in response to the OMI recommendations.[28] However, the OIG identified the lack of documentation of VISN surgical workgroup discussions.

The VCSC chairs the VISN surgical workgroup and oversees "compliance with VHA surgical and related policy across the VISN." VHA also requires the surgical workgroup to monitor "performance improvement activities within the VISN to ensure systems issues are addressed."[29] The OIG learned the VCSC provided facility oversight through monthly VISN workgroups, quarterly meetings with leaders from each VISN facility, and site visits. A February 2022 site visit to the facility resulted in the VCSC's recommendations to increase the number of providers and staff as well as administrative support, such as a residency site coordinator.[30]

The OIG reviewed VISN 10 surgical workgroup meeting minutes and found this documentation did not capture any discussion regarding (1) facility compliance with the policies reviewed; (2) the impact of vacancies on the facility surgical complexity level; or (3) actions taken to bring the facility into compliance. The OIG expects the VISN surgical workgroup would be a forum for discussion of these actions as there may be application to other VISN facilities and directly address VHA policy compliance.

The OIG found that the VCSC was responsive to VISN and facility leaders' requests to review the former chief of surgery's clinical care, conducted on-site visits to the facility, and had regular contact with the COS. However, the OIG found the VISN surgical workgroup did not document vital information from the facility, which could have ramifications VISN-wide.

OIG-Identified Concern Regarding Instability in Facility Leadership

The OIG found that from November 2021 through January 2023, three of five executive leaders

[27] VHA Directive 1400.01.

[28] Per the VCSC, who reported being in the role three to four years at the time of the inspection, approximately 50 percent of work hours were dedicated to the role of chief of surgery at another VISN 10 facility and the other 50 percent of time was dedicated to VISN activities.

[29] VHA Directive 1102.01(2).

[30] The VCSC reported meeting with the facility interim COS regularly and conducted an additional site visit to the facility in July 2022. The VCSC also reported being available for additional consultation as needed.

at the facility were serving in an interim capacity.[31] Between December 2021, through January 2023, interim leadership included the Facility Director; COS; Associate Director for Patient Care Services; chief of surgery; and the chief of quality, safety, and value. Each of these positions had a role in the facility leaders' corrective actions in response to the OMI recommendations and VISN site visit recommendations. The OIG found that VISN executive leaders actively engaged and supported facility leaders through a period of leadership transition in January 2023 and expects that this support will continue through ongoing transitions until permanent leadership is in place.

The VISN Director told the OIG that the interim facility leaders were "a little on edge;" subsequently, the VISN Director recognized the need for additional support. In January 2023, the VISN Director implemented a plan that included a schedule of weekly VISN executive leadership visits to the facility to increase visibility during upcoming leadership changeover.

The OIG is concerned that the facility leaders' corrective actions in response to OMI recommendations may not be sustainable due to frequent changes to key facility leadership positions. The OIG has identified in other reports that frequent turnover, vacancies, and long-term use of leaders in interim positions have significant negative consequences for facilities.[32] The OIG found that VISN executive leaders recognized the facility was vulnerable during times of leadership transition. Further, VISN executive leaders were committed to supporting the facility through these transitions to ensure the sustainability of corrective actions and facilitate ongoing leadership transitions.

Impact of Facility Leaders' Actions on HRO Principles

The OIG found that since July 2022, interim facility leaders had instituted several HRO initiatives aimed at improving communication, establishing governance policy, and increasing psychological safety. However, the OIG is concerned that if previous leaders return, or temporary leaders have short appointment periods, the facility could lose any forward progress made toward HRO goals.

Communication Silos

VISN leaders reported concerns with the Facility Director's control over communication and

[31] VA Handbook 5005, *Staffing*, April 15, 2002. "If a replacement is required while the incumbent is on extended leave, an interim position may be established. Generally, interim positions will be terminated within 1 year or less."

[32] VA OIG, *Comprehensive Healthcare Inspection of Veterans Integrated Service Network 5: VA Capitol Health Care Network in Linthicum, Maryland*, Report No. 21-00239-180, July 14, 2022. VA OIG, *Descriptive Analysis of Select Performance Indicators at Two Healthcare Facilities in the Same Veterans Integrated Service Network*, Report No. 20-02899-22, November 16, 2021. VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-00497-161, July 11, 2019.

decision-making and limited communication across services. The OIG found that key leadership positions like the interim chief of surgery and interim chief of quality, safety, and value did not have full knowledge of the OMI report and recommendations, despite sharing responsibilities for corrective actions.

The VISN Director described previous facility leadership as having had "siloed communication routes" where "there was not a lot of cross communication across services." The VISN Quality Management Officer (QMO) indicated concerns that the previous Facility Director attempted to manage the OMI report recommendations with a small group, which limited transparency and the ability to discuss corrective actions.[33] After a June 2022 site visit, the VISN Chief Nursing Officer also recommended facility leaders improve communication as "there is an opportunity to be sensitive to operations, engaging nurse leaders and front-line staff in their work area changes."

The interim Facility Director 1 and the VISN Director told the OIG that communication changes, such as facility-wide daily safety huddles and town halls, made by interim leaders were well-received by facility staff. The VISN Director stated "[It's going to] take time, but it needs the right leader, and it needs some permanent leadership in those roles. . . it's going to be some time before we get those."

The OIG expected that facility leaders would have provided the OMI report to those leaders responsible for corrective actions and coordination of responses. Though the OIG noted interim facility leaders' reduced communication silos with facility staff, the OIG is concerned that the changes may not be sustainable due to the temporary nature of facility leader assignments.

Lack of Governance and Policy Management

Through interviews with VISN and facility leaders and document reviews, the OIG learned the facility had lacked formal governance structures and policies.[34] In 2022 interim facility leaders demonstrated a commitment to HRO principles through development of a governance, leadership, and culture policy to support transparency, though the OIG noted these changes were new at the time of inspection.

During a June 2022 site visit, the VISN Chief Nursing Officer recommended facility leaders update the committee structure and in July 2022, interim Facility Director 1 also noted concerns regarding the facility's lack of formalized governance processes. Interim Facility Director 1 addressed this concern by publishing a medical center policy that outlined facility governance

[33] The VISN QMO identified the previous Facility Director and the interim Chief of Staff as part of the "small group" but was unable to identify others involved.

[34] "Merriam-Webster.com Dictionary, "governance," accessed February 23, 2023, https://www.merriam-webster.com/dictionary/governance. The act or process of governing or overseeing the control and direction of something (such as a country or an organization). VHA Directive 0999, *VHA Policy Management*, March 29, 2022.

and set expectations for facility leadership and culture.

The OIG noted that facility leaders had not recertified, or revised, as required, facility policies related to peer review, credentialing, verification of licensure, and disciplinary actions in over five years. Additionally, quality, safety, and value, and surgical service leaders had not used charters, as VHA required, to establish and outline the responsibilities and functions for quality management such as Peer Review Committee processes and M&M conferences.[35] However, the OIG also found improvements made by interim leaders' demonstrated commitment to HRO principles, including changes to the facility's peer review case selection process.

The OIG recognizes the progression of governance and policy management will challenge incoming interim leaders. Therefore, sustainability and continuation of the facility's HRO efforts requires ongoing VISN oversight and support. The facility should continue progress toward establishing governance and policy to support transparency and facilitate leadership transitions.

Psychological Safety

The CMO reported historical concerns of facility staff regarding lack of psychological safety and shared "there was a pervasive attitude that employees were afraid to speak up; that made it quite challenging… [it] was pervasive in Detroit." During a June 2022 site visit, the VISN Chief Nursing Officer documented concerns regarding psychological safety at the facility and subsequently made recommendations for improvement. Another recommendation made during the quality management site visit was to establish an HRO lead position; the position was filled in September 2022. In October 2022, the HRO lead began attending the Peer Review Committee and the facility risk manager told the OIG that the committee had become more psychologically safe.

The OIG concluded interim facility leaders had made efforts to improve psychological safety at the facility, including the creation of a SharePoint site for anonymous submission of concerns and an improved leadership rounding process. The OIG expects facility and service leaders to continue to create and promote a psychologically safe environment.

VISN Leaders' Ongoing Oversight and Support

The OIG evaluated VISN leaders' oversight and interviewed VISN leaders and the VCSC to identify actions taken to ensure facility leaders had the tools and support necessary to implement sustainable solutions to OMI-identified concerns. Through site visits related to the OMI recommendations, VISN leaders identified further concerns and addressed those concerns

[35] VHA Directive 0999. Charters establish "and outlines the responsibilities and function of a committee, council. . . or equivalent type of standing group." The OIG learned that quality management staff were assisting in the development of a charter for Peer Review Committee; however, the charter was not signed by interim Facility Director 1 as of December 2022.

promptly. However, the OIG concluded that continued support is necessary as executive leadership roles at the facility are in an interim status due to pending administrative investigations.

When asked why VISN leaders were not aware of the above noted facility issues prior to the OMI report, the VISN Director told the OIG that, clinical care metrics did not trigger reviews under the previous leadership and there were not "a lot of patient complaints" made to the VISN. The OIG found that VISN leaders' actions were responsive to multiple investigations or reviews around the former chief of surgery's care and leadership style. Further, the interim COS reported satisfaction with support from the VISN, including multiple VISN site visits to the facility, to address issues such as psychological safety and communication with leaders at the facility in addition to the surgery service.

The OIG found VISN leaders demonstrated commitment to enhanced oversight during current and upcoming facility leadership transitions. However, the OIG is concerned that the delay in revoking the former chief of surgery's privileges and reporting to external entities suggests opportunities for improvement in communication during periods of transition. On December 2, 2022, the VISN Director issued a memo to the VISN executive leadership team to plan for increased visibility during facility leadership transitions. The memo noted, "[g]iven the instability of Detroit leadership and vulnerabilities identified over the last year, providing additional VISN oversight during this transition is necessary to ensure optimal functioning of the health care system and sustainment of the actions identified over the last 6 months."[36]

The OIG made four recommendations to the VISN Director related to compliance with VHA requirements regarding resident supervision, the VISN academic affiliation officer's awareness, and performance of assigned roles and responsibilities; the VISN surgical workgroup review of applicable policies and documentation of discussion and action plans; and the provision of continued oversight and support to executive and service line leaders during key leader transitions.

The OIG made five recommendations to the Facility Director regarding review of, and response to, the NSO program review as well as NPDB and SLB reporting of healthcare providers meeting reporting criteria; facilitation and oversight of M&M conferences; neutral reassessment of Peer Review Committee members' cases; and review of organizational communication channels to ensure consistency with HRO goals as well as consideration of resources such as VHA National Center for Organization Development.

[36] The plan includes increased direct on-site availability, monitoring of facility action plans, and attendance at executive huddles.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General
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Contents

Executive Summary i

Abbreviations xviii

Introduction 1

Scope and Methodology 4

Inspection Results 6

Synopsis of Review 6

1. Review of General Surgery Residency Program and Oversight 6

2. Review of National Surgery Office Consultation 9

3. Review of External Reporting 11

4. General Surgeon Staffing, Privileging, and On-call Response Times 16

5. Review of Quality Management Processes 19

6. Review of VISN Oversight and Support—General Surgery and COS 24

7. OIG-Identified Concern Regarding Instability in Facility Leadership 29

8. Impact of Facility Leaders' Actions on HRO Principles 31

9. VISN Leaders' Ongoing Oversight and Support 35

Conclusion 36

Recommendations 1–9 39

Appendix A: VISN Director Memorandum 41

Appendix B: Facility Director Memorandum 46

OIG Contact and Staff Acknowledgments 50

Report Distribution 51

Abbreviations

CMO	Chief Medical Officer
COS	Chief of Staff
HRO	High Reliability Organization
M&M	Morbidity and Mortality
NPDB	National Practitioner Data Bank
NSO	National Surgery Office
OIG	Office of Inspector General
OMI	Office of the Medical Inspector
PGY-1	post-graduate year one
QMO	VISN Quality Management Officer
SLB	State Licensing Board
VCSC	VISN chief surgical consultant
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection of the John D. Dingell VA Medical Center (facility) in Detroit, Michigan, to assess leaders' progress toward implementation of the Veterans Health Administration (VHA) Office of the Medical Inspector (OMI) report recommendations and to evaluate Veterans Integrated Service Network (VISN) 10 leaders' oversight and support provided to the facility.

During the inspection, the OIG identified concerns surrounding past facility leaders' failure to incorporate High Reliability Organization (HRO) practices, including bi-directional communication, governance and policy management, and promoting a psychologically safe environment.[1]

Background

The facility, part of VISN 10, includes a 105-bed hospital and two community based outpatient clinics located in Pontiac and Yale, Michigan.[2] VHA classifies the facility as mid-high complexity level 1c, providing primary care and a full array of medical, surgical, and mental health services including cardiac care, cancer care, orthopedics, women's health, sleep clinic, audiology, vision, dental, mental health, and substance abuse treatment.[3] From October 1, 2020, through September 30, 2021, the facility served 44,797 patients.

At the time of the inspection, the facility was assigned an inpatient invasive procedure complexity designation and reported completion of 2,586 invasive procedures from July 1, 2021,

[1] VA, VHA, "VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only," September 2022. "High reliability means evidence-based, high-quality care is consistently delivered for every patient, every time, at any facility across VHA." VHA began implementing HRO practices in 2018 and was implementing HRO enterprise-wide as of September 2022. "VHA's Journey to High Reliability is a long-term commitment to our Veterans and our workforce to continuously improve and advance toward Zero Harm. . . [supporting] our efforts to regain the trust of Veterans."

[2] VISN 10 facilities include: VA Ann Arbor Healthcare System, Battle Creek VAMC, Chillicothe VAMC, Cincinnati VAMC, Louis Stokes Cleveland VAMC, Chalmers P. Wylie VA Ambulatory Care Center, Dayton VAMC, John D. Dingell Detroit VAMC, VA Northern Indiana Health Care System, Richard L. Roudebush Indianapolis VAMC, and Aleda E. Lutz Saginaw VAMC. The VISN 10 office is located in Cincinnati, Ohio, and a satellite office is located in Ann Arbor, Michigan.

[3] VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes each medical facility by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex; level 3 facilities are the least complex.

through June 30, 2022.[4] The facility offered the following surgical specialties: ear, nose, throat, general, gynecology, ophthalmology, orthopedic, plastic, podiatry, thoracic, urology, and vascular.[5] The facility had academic affiliations with four health trainee institutions including Wayne State University School of Medicine (sponsoring institution), and provided trainee education to 519 physician residents, including seven general surgery residents, from July 1, 2021, through June 30, 2022.

Office of the Medical Inspector

Established in 1980, the OMI reports directly to the Under Secretary for Health.[6] The OMI assesses and reports on healthcare issues raised by veterans and other stakeholders to improve the quality of VA health care.[7] The OMI investigative teams conduct site visits, document findings, and require facilities to submit corrective action plans to address associated recommendations. While the OMI functions independently within VHA, the OIG provides oversight of the OMI's activities.[8]

Prior OIG Reports

In June 2017, the OIG published *Alleged Mismanagement and Quality of Care Issues in Surgical Service, John D. Dingell VA Medical Center Detroit, Michigan*.[9] The OIG reviewed allegations related to the former chief of surgery's negative behaviors, reduced surgical access, difficulty adhering to surgical resident supervision guidelines, artificially increased surgical volume, performance of procedures without available equipment, and poor clinical decision-making.[10] The OIG made eight recommendations to the facility related to communication in the operating

[4] VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in any Clinical Setting*, May 13, 2019, amended February 11, 2020. "Inpatient complex invasive procedures require a dedicated critical care service providing 24/7 coverage and daily multidisciplinary rounds, specialized technology and board-certified specialists depending on the approved invasive programs, dedicated in-house 24/7 coverage of invasive patients and a readily available OR [operating room] call team for emergency and salvage procedures."

[5] "Definitions of ABS Specialties" (web page), The American Board of Surgery, accessed January 31, 2023, https://www.absurgery.org/default.jsp?public_definitions. General surgery is defined as "expertise in the diagnosis and care of patients with diseases and disorders affecting the abdomen, digestive tract, endocrine system, breast, skin, and blood vessels. A general surgeon is also trained in the treatment of patients who are injured or critically ill, and in the care of pediatric and cancer patients. General surgeons are skilled in the use of minimally invasive techniques and endoscopies."

[6] VHA Directive 1038, Role of the Office of the Medical Inspector, August 2, 2017.

[7] "VHA Office of the Medical Inspector" (web page), *Veterans Health Administration*, accessed January 31, 2023, https://www.va.gov/health/medicalinspector.

[8] VHA Directive 1038.

[9] VA OIG, *Alleged Mismanagement and Quality of Care Issues in Surgical Service, John D. Dingell VA Medical Center, Detroit, Michigan*, Report No. 15-02994-269, June 19, 2017.

[10] While the previous OIG report utilized the title "Associate Chief of Staff of Surgical Services," this report will use the title "chief of surgery" as the OMI report and facility leaders and staff used this title.

room, operating room scheduling processes, completion of post-operative notes, documentation of the presence of supervising physicians in the operating room, designation of back-up surgeons, and reviews of clinical care, autopsies, and peer review policy compliance. All recommendations are closed.

Request for Review and Related Concerns

In November 2021, the OMI investigated allegations regarding quality of care, to include a review of care rendered, at the facility. In April 2022, the OMI issued inspection findings that resulted in 10 recommendations regarding provider oversight, surgical services, and quality reviews.[11]

In response to a congressional request from Senators Gary Peters and Debbie Stabenow, and Representatives Debbie Dingell and Rashida Tlaib, the OIG opened a hotline inspection to assess the facility's progress toward implementation of OMI's recommendations and to evaluate VISN 10 leaders' oversight of, and support provided to, the facility. Specifically, the inspection reviewed

- general surgery residency program and oversight,
- National Practitioner Data Bank (NPDB) reporting,
- National Surgery Office (NSO) consultation,
- general surgery staffing, privileges, and on-call processes,
- quality management processes, and
- VISN 10 oversight and support.[12]

During the course of the inspection, the OIG identified the following additional concerns that were not resolved through the facility and VISN's responses to the OMI report

- supervision of post-graduate year 1 (PGY-1) residents,

[11] *Report to the Under Secretary for Health, John D. Dingell Veterans Affairs Medical Center, Detroit, Michigan*, TRIM 2021-C-51, April 16, 2022. The Deputy Under Secretary for Health approves distribution of OMI reports. The 2022 OMI report resulted in 12 recommendations; however, the OIG evaluated 10 of the OMI recommendations, as the remaining 2 recommendations pertained to administrative issues outside of the scope of this review.

[12] The NPDB is a reporting repository where hospital and other health care entities report concerns or actions regarding providers. The purpose of reporting is to promote "quality health care and [deter] fraud and abuse within health care delivery systems." *"National Practitioner Data Bank, About Us" (web page),* US Department of Health and Human Services, accessed March 6, 2023, https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp. Reporting criteria includes "adverse clinical privileges actions related to professional competence or conduct." "*National Practitioner Data Bank, The NPDB Guidebook, Definitions" (webpage),* US Department of Health and Human Services, accessed March 6, 2023, https://www.npdb.hrsa.gov/guidebook/CDefinitions.jsp.

- State Licensing Board (SLB) reporting,
- surgical leader participation in morbidity and mortality (M&M) conferences,
- peer reviews of Peer Review Committee members,
- VISN oversight of the Academic Affiliations Program,
- significant and frequent key leadership changes leading to governance instability, and
- facility leaders' adherence to HRO goals.[13]

Scope and Methodology

The OIG initiated the inspection on October 5, 2022, and conducted an on-site visit November 29 through December 1, 2022. The OIG conducted additional virtual interviews through April 3, 2023.

The OIG interviewed VISN and facility executive leaders; VISN program office staff; the facility interim chief of surgery; a surgery service administrative staff member; service leaders; general surgeons; a general surgery site director; a medical school general surgery program director; a quality, safety and value leader and staff member; a credentialing and privileging leader and staff member; a surgical quality nurse; a surgical intensive care unit nurse; an operating room nurse leader; and a general surgery chief resident.[14] While on-site, the OIG interviewed interim Facility Director 1, who served in this role from July 5, through December 31, 2022.[15]

[13] VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. A Post Graduate Year-1 (PGY-1) resident, also known as an "intern," is a health professional trainee in a graduate training program and in the first year of post-graduate clinical training. VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A facility Peer Review Committee is comprised of the Chief of Staff, or designee; key clinical leaders; and other appropriate clinical peers.

[14] The CMO had served as the interim CMO from January through November 2022, when the appointment became permanent. The OIG also interviewed the following interim leaders and staff: Facility Director 1; Chief of Staff; chief of surgery; chief of quality, safety, and value; and a credentialing and privileging supervisor. All other interviewees from the facility were in permanent appointments.

[15] The Facility Director began a detail to a position in VA Central Office in July 2022. The report also identifies interim Facility Director 2, who assumed this role on January 1, 2023.

The OIG reviewed the 2017 OIG report and the 2022 OMI report, including an OMI action plan used to document VHA responses to recommendations.[16] The OIG also reviewed relevant VHA directives, handbooks, and guidelines as well as applicable Accreditation Council for Graduate Medical Education guidelines. The review also included facility policies and procedures related to surgery and the supervision of residents, medical staff by-laws, committee meeting minutes, academic affiliation agreements, as well as surgery call schedules.[17] Further, the OIG reviewed the documented actions taken by VISN and facility leaders in response to the OMI recommendations, including action plans, internal and external reviews, and email communications. Lastly, the OIG analyzed three VHA clinical reviews of the former chief of surgery's care. The OIG did not independently verify the reviews for accuracy or completeness.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

[16] The OMI provided the OIG with three action plans used to communicate the status of corrective actions taken to address the OMI's recommendations and document the status of the recommendation (i.e., open or closed). The action plans included narrative comments and documents embedded by the facility that were used as evidence to close recommendations. The OIG review of documentation included both embedded documents and narrative statements provided by facility and VISN leadership. The OIG did not independently validate the OMI's review and findings.

[17] The OIG reviewed Peer Review Committee minutes, Morbidity and Mortality Conference minutes, and VISN Surgical Workgroup minutes.

Inspection Results

Synopsis of Review

The OIG reviewed the OMI report and VHA action plans as well as documentation submitted in response to the OMI recommendations. Generally, the OIG found the majority of VHA responses sufficient to address the elements of the OMI recommendations. This report documents gaps and deficiencies requiring additional VHA follow-up in instances where the OIG determined the response to be insufficient, or where the OIG identified related concerns not included in the OMI report.

The OIG also evaluated VISN leaders' oversight of the facility and interviewed select VISN leaders to identify actions taken to ensure facility leaders had the tools and support necessary to implement sustainable solutions to the concerns identified by the OMI. The OIG interviewed the VISN Director, Chief Medical Officer (CMO), Quality Management Officer (QMO), and chief surgical consultant (VCSC) as these leaders were in the best position to facilitate action plans and provide support to facility leaders following the OMI report. Notably, the VISN Director was appointed to the role in May 2022 and told the OIG of being briefed by the VISN Deputy Director of the OMI findings and concerns related to the facility surgery service.[18] According to the VISN Director, during a VISN site visit to the facility in June 2022, the VISN Chief Nursing Officer and QMO informed the VISN Director of concerns, such as workplace culture issues, that "warranted additional dig-ins," prompting the VISN Director to engage requisite VISN program directors to resolve these issues.

The OIG found the VISN leaders' actions to be timely and responsive to facility needs in the months following the issuance of the OMI report. The OIG also reviewed if the VISN and facility leaders' actions lead to sustainable change and ongoing quality and provider oversight. Given the acting and interim status of many key leadership positions, the OIG concluded that continued VISN support is critical through current and upcoming facility leadership transitions to ensure sustainable improvements and completion of remaining corrective actions.

1. Review of General Surgery Residency Program and Oversight

As the largest provider of health professional education in the United States, VHA identifies that a clear delineation of oversight responsibilities for supervisors of trainees is imperative to ensure veterans receive high-quality patient care.[19] The OMI made one recommendation regarding

[18] The VISN 10 Deputy Director served as Interim VISN Director from November 15, 2021, through the permanent appointment of the VISN Director on May 8, 2022. The VISN Director told the OIG that the VISN Deputy Director had briefed the VISN Director on the OMI report during the first week of the appointment.

[19] "Office of Academic Affiliations" (web page), VA, accessed January 31, 2023, http://www.va.gov/oaa; VHA Directive 1400.01.

general surgical residency program oversight. While the OIG did not have concerns with the facility leaders' corrective actions, upon review of general surgery resident supervision at the facility, the OIG identified a concern regarding PGY-1 general surgery resident supervision.

Supervision of Residents

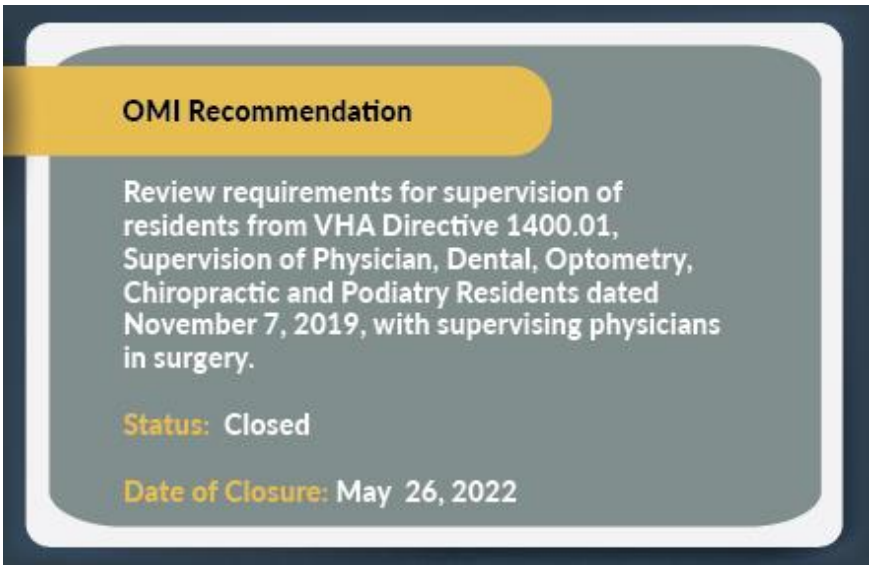

Figure 1. *OMI Recommendation: Review of General Surgery Residency Program and Oversight. Source: OMI Report, April 16, 2022, and OMI recommendation status.*

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation. The documentation included

- review of surgical resident oversight directives during monthly meetings with surgery staff,
- email communications to the surgery service regarding resident supervision,
- appointment of a new residency site director,
- plans to hire a new residency site coordinator, and
- daily self-auditing of residency oversight in the electronic health record.[20]

While the OIG determined that the facility leaders' corrective actions were responsive to the recommendation, the OIG also noted a gap regarding supervision of PGY-1 general surgery residents while on-call overnight at the facility.

[20] A surgical services staff member told the OIG that the residency site coordinator position remained vacant as of February 2023. Initial attempts to fill the position were unsuccessful and the position was reposted in February 2023.

OIG-Identified Concern Regarding Supervision of PGY-1 Residents

During the review, the OIG found that PGY-1 general surgery residents were not supervised per VHA requirements and that an additional facility in the VISN did not follow VHA PGY-1 general surgery resident supervision requirements.[21] The OIG considered the lack of direct supervision of PGY-1 general surgery residents a significant patient safety risk as PGY-1 residents may not have the experience required to provide competent and independent patient care.

VHA requires that PGY-1 residents "have on-site supervision at all times by either a supervising practitioner or a more advanced resident, with the supervising practitioner being available on-call."[22] A general surgeon and a general surgery resident told the OIG that PGY-1 general surgery residents provided overnight coverage without direct supervision. Specifically, when PGY-1 general surgery residents were on-call in the facility overnight, the senior resident and on-call attendings were off-site but available by phone.

Due to patient safety concerns, the OIG shared this finding with facility and VISN leaders during the site visit exit briefing. Facility leaders reported unawareness of the PGY-1 supervision requirement and discussed options for compliance immediately after the briefing.[23] Following the OIG site visit, the interim Chief of Staff (COS) told the OIG facility leaders had begun corrective actions, which included a temporary plan of having an attending or a more advanced resident on-site overnight to provide direct supervision to PGY-1 general surgery residents through the month of December 2022, with a revised and compliant resident on-call model to start in 2023.[24] This new model has a more advanced resident on-call daily in lieu of the previous model that relied on PGY-1 general surgery residents taking call daily. Further, the new model pairs a PGY-1 general surgery resident with a more advanced resident on-call two nights a week. The new model also ensures an attending is available to take call while off-site to support the residents who take call on-site. The sponsoring institution general surgery program director later reported being unaware of the VHA requirement regarding on-site PGY-1 resident supervision and explained that Accreditation Council for Graduate Medical Education guidelines allowed for indirect supervision of PGY-1 residents with program director approval. The program director

[21] VHA Directive 1400.01.

[22] VHA Directive 1400.01.

[23] VHA Directive 1400.01.

[24] VHA Directive 1400.01. An attending is a senior physician who serves as a supervisor to residents who are in advanced medical training. For the purposes of this report, a more advanced resident is any resident PGY-2 or later in training.

assured the OIG of efforts to work with the facility team and comply with VHA requirements going forward.[25]

The VCSC told the OIG that the interim COS had shared the OIG's finding regarding PGY-1 general surgery resident direct supervision. The VCSC subsequently reviewed the models of PGY-1 resident supervision across the VISN to determine whether the models met VHA requirements. Upon review, the VCSC identified one additional facility in the VISN that was not meeting the PGY-1 resident supervision requirement and told the OIG that in January 2023, the facility implemented a revised model that was compliant with direct supervision.

The OIG found facility leaders did not meet VHA requirements related to the supervision of PGY-1 general surgery residents.[26] However, when the OIG identified this concern, facility leaders took immediate steps to ensure compliance. Further, upon the VCSC's review of general surgery resident supervision throughout the VISN, and the identification of an additional non-compliant facility, sufficient corrective actions were taken to ensure compliance across the VISN.

2. Review of National Surgery Office Consultation

The NSO is responsible for policy that impacts the delivery of surgical care provided by VHA and oversight of surgical programs and outcomes.[27]

[25] VHA Directive 1400.03, *Educational Relationships,* February 23, 2022. The sponsoring institution is the academic affiliate that sponsors the residency program. The sponsoring institution program director is usually a non-VA employee, paid by the sponsoring institution, who is based at the sponsoring institution site. Accreditation Council for Graduate Medical Education, *ACGME Program Requirements for Graduate Medical Education in General Surgery,* July 1, 2020. Although PGY-1 residents require initial direct supervision, the program director can identify tasks that a PGY-1 resident can perform with indirect supervision once residents demonstrate competence.

[26] VHA Directive 1400.01.

[27] "Surgical Services-National Surgery Office (NSO)" (website), VA, http://vaww.dushom.va.gov/surgery/index.asp. (This website is not publicly accessible.)

National Surgery Office Consultation and Review of the Former Chief of Surgery's Cases

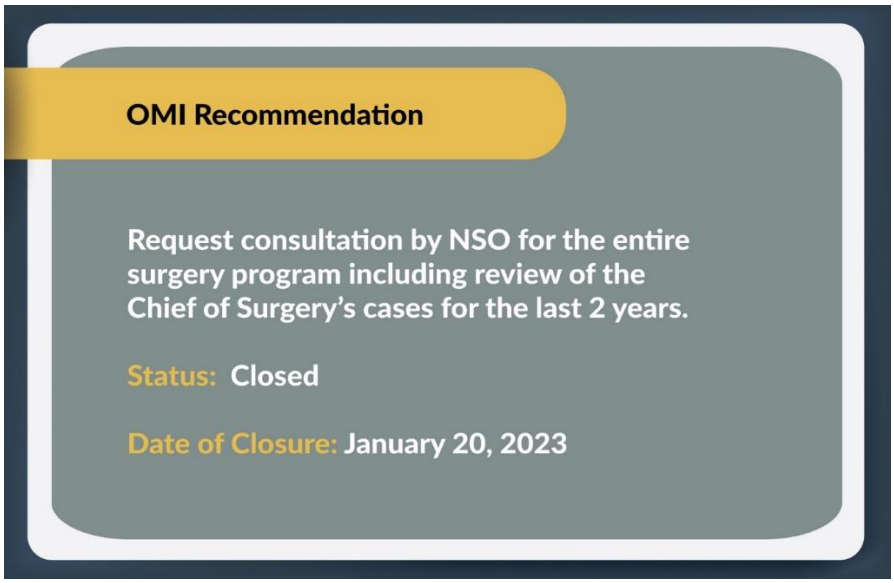

Figure 2. *OMI Recommendation: National Surgery Office Consultation and Review of the Former Chief of Surgery's Cases.*
Source: OMI Report, April 16, 2022, and OMI recommendation status.

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation. The documentation included details of a meeting with the interim COS and the National Surgery Director in May 2022 to discuss the retrospective case reviews of the former chief of surgery's patient care as well as a summary of the retrospective case review.

The summary, reported by the interim COS to OMI, described the retrospective case reviews of 410 cases, which reportedly represented 100 percent of cases performed by the former chief of surgery from May 2020 through August 2021 (see table 1).[28]

Table 1. Summary of Retrospective Case Reviews of the Former Chief of Surgery's Patient Care

Review	Review Completion	Number of Cases Reviewed	Findings
Peer Review	FY 2020	23	5 "level 3" peer reviews*
National/VISN Review	FY 2021, fourth quarter	54	6 cases did not meet standard of care

[28] Per the interim COS, the former chief of surgery did not perform any cases after August 2021. Outcomes of the peer reviews for quality management are not discussed further in this report as these are quality management activities that can generate confidential records and documents under Title 38 United States Code (U.S.C.) § 5705.

Review	Review Completion	Number of Cases Reviewed	Findings
VISN Review	FY 2022, third quarter	60	11 cases did not meet standard of care
VISN Review	FY 2023	273	7 cases did not meet standard of care

Source: Summary of retrospective case reviews of the former chief of surgery's cases from May 2020 through August 2021, reported by the interim COS to the OMI.
Note: The fiscal year (FY) is broken into four, three-month quarters, which are: first quarter: October 1 – December 31; second quarter: January 1 – March 31; third quarter: April 1 – June 30; and fourth quarter: July 1 – September 30.
** Level 3 is the level at which experienced and competent clinicians would have managed the case differently.*

In January 2023, the OMI closed the recommendation based on completion of the retrospective review and the pending issuance of a report related to the NSO surgical program consultation.[29] In March 2023, the NSO issued a memorandum documenting a program review of the facility surgery service; the memorandum included recommendations related to oversight, leadership support and communication, and peer review. The NSO also recommended facility leaders develop "a strategic plan for the surgery service to include surgical safety, quality, access, [and] operational efficiency."[30] The OIG identified the need for facility leaders to ensure a comprehensive and sustainable response to the recommendations noted in the NSO memorandum.[31]

3. Review of External Reporting

VHA requires external reporting of certain malpractice payments and clinical privileging actions for VA practitioners to the NPDB and SLB.[32] One purpose of external reporting, when appropriate, is to prevent providers from being able to move to different employment without disclosure of incompetent performance.[33] The OMI made one recommendation regarding NPDB reporting. Upon review of the facility leaders' response to the recommendation, the OIG

[29] The OIG interviewed the OMI inspection team who stated that they closed the recommendation in January 2023 as they were aware of the results in the pending NSO report and believed the report met the intent of the OMI recommendation.

[30] NSO National Director of Surgery, "Program Review, John D. Dingell VA Medical Center Surgery Program," memorandum to the Acting Director, John D. Dingell VA Medical Center, March 20, 2023.

[31] On April 6, 2023, the interim chief of quality, safety, and value provided the OIG with an action plan developed in response to the NSO review.

[32] VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, December 28, 2009.

[33] *"National Practitioner Data Bank, About Us" (web page),* US Department of Health and Human Services, accessed March 6, 2023, https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp.

identified additional concerns regarding the delay of a proposed privileging action and missed opportunities for SLB reporting regarding the former chief of surgery.

National Practitioner Data Bank Reporting

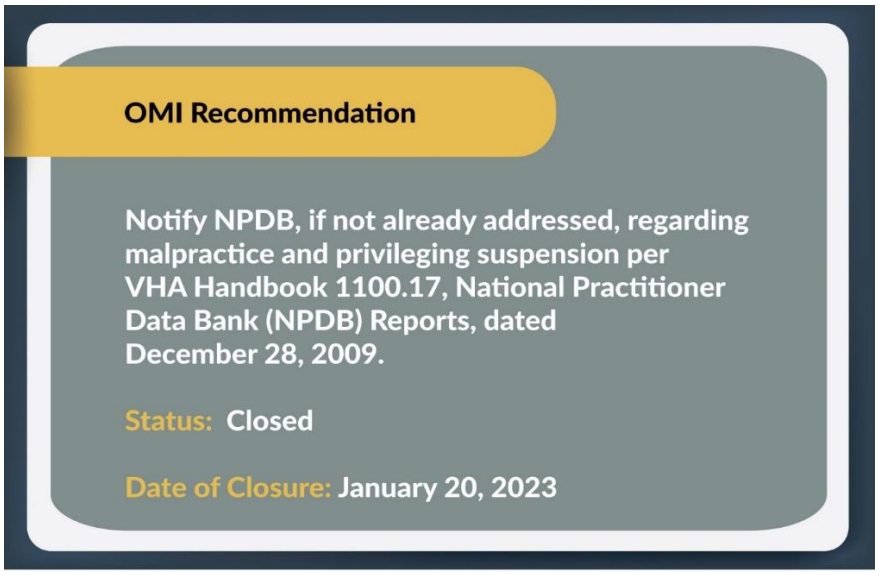

Figure 3. *OMI Recommendation: National Practitioner Data Bank Reporting*
Source: OMI Report, April 16, 2022, and OMI recommendation status.

VHA requires a facility director report health care providers to the NPDB if either of the following are applicable: payments are made because of a settlement or judgment of a claim of malpractice or if there are final adverse clinical privilege actions in effect for longer than 30 days.[34]

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation. The documentation included

- a statement that VA's Office of Medical-Legal Affairs determines whether a provider's malpractice settlement is reportable to the NPDB;
- the facility's attestation that the Office of Medical and Legal Affairs had not asked the facility to report the former chief of surgery to the NPDB; and
- a decision made by interim Facility Director 2 to pursue revocation of the former chief of surgery's clinical privileges.

[34] VHA Handbook 1100.17. The handbook further notes that examples of adverse clinical privilege actions include restriction, suspension, and revocation. Summary suspension of clinical privileges is not reportable until an adverse final action is made by the Facility Director.

Upon review, the OIG identified an additional concern with the corrective actions taken that led to closure of this recommendation in January 2023. Specifically, there was a delay in processing a recommendation to revoke the former chief of surgery's clinical privileges that would support NPDB reporting.

OIG-Identified Concern Regarding Delay in Privilege Revocation

As a result of concerns raised about those aspects of the former chief of surgery's clinical practice that "[did] not meet accepted standards and potentially constitute an imminent threat to patient safety," the interim COS recommended the suspension of the former chief of surgery's clinical privileges. Subsequently, the Facility Director summarily suspended the former chief of surgery's clinical privileges as of June 13, 2022. The Clinical Executive Committee held a meeting in October 2022 and discussed the completed VISN review of 60 cases performed by the former chief of surgery and voted to recommend reinstating the former chief of surgery's clinical privileges. In an OIG interview, interim Facility Director 1 reported nonconcurrence with the Clinical Executive Committee decision and recommended the revocation of clinical privileges for the former chief of surgery on November 28, 2022. On February 27, 2023, after the OIG's third request for an update of the status of the former chief of surgery's clinical privileges, a VISN representative provided evidence that the Clinical Executive Committee met again on January 23, 2023, discussed the NSO's review, and voted to recommend the revocation of the former chief of surgery's clinical privileges. A VISN representative informed the OIG that interim Facility Director 2 concurred with the Clinical Executive Committee's recommendation and forwarded the revocation memorandum to human resources.

When asked about the outcome of the initial revocation recommendation made in November 2022, a VISN representative stated that, "due to the complexity of the case, multiple investigations, and the discordance between the [Clinical Executive Committee] and [interim] Director recommendations, it [took] an extended length of time to draft this letter."

While the OIG acknowledges that it takes time to carefully review clinical activities, the OIG opined that the two-month processing delay on a final adverse clinical privilege action, reportable to the NPDB, undermined the intent of NPDB reporting, which is meant to prevent providers from being able to move to different employment without disclosure of incompetent performance. The NPDB reporting delay is also an example of siloed communication and reflects the need for additional VISN oversight, intervention, and support.

OIG-Identified Concern Regarding State Licensing Board Reporting

During a review of the facility leaders' response to the NPDB recommendation, the OIG identified an additional concern regarding SLB reporting.[35] The OIG found that in two clinical reviews of the former chief of surgery's care performed prior to this inspection, VHA reviewers identified 16 episodes of substandard care that met the requirements to initiate the SLB reporting process in the state(s) in which the former chief of surgery was actively licensed.

VHA has broad authority to report providers to SLBs:

> It is VHA policy to report to SLBs regarding current or separated VHA licensed health care professionals . . . when substantial evidence supports a reasonable conclusion that the professional's clinical practice during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients or the community.[36]

Per VHA directive, facility directors have ultimate decision authority to determine whether clinical care provided by a VA provider failed to meet generally accepted standards of clinical practice to the extent that a safety concern is raised. In such cases, SLB reporting must be initiated immediately.[37] A VA-initiated report to an SLB only serves as a notice that there is a question of the provider's clinical practice; it does not indicate a VA action against the provider's license. Additionally, an SLB may or may not investigate, or take formal action against a provider's license, consistent with that state's SLB policies and procedures.[38]

The VHA SLB reporting process involves five stages and is to be initiated within five business days of a supervisor's awareness that a provider potentially failed to meet generally acceptable standards in one or more episodes of care. The first stage involves an initial review to determine if there is evidence to support meeting the reporting threshold. Further, reporting must not wait until completion of a personnel or privileging action.[39]

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[35] The Facility Director summarily suspended the former chief of surgery's clinical privileges in August 2021. The interim COS told the OIG that the former chief of surgery had not performed any surgeries at the facility since August 2021. The interim COS permanently reassigned the former chief of surgery to a general surgeon position in January 2022. The former chief of surgery was removed from employment at the facility in April 2023. The OMI recommendations did not address SLB reporting.

[36] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. The directive defines substantial evidence as "the degree of relevant evidence that. . . a reasonable person might accept as adequate to support a conclusion, even if it is possible to draw contrary conclusions from the evidence, for believing that the professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients or the community."

[37] VHA Directive 1100.18.

[38] VHA Directive 1100.18.

[39] VHA Directive 1100.18.

The OIG analyzed the following quality reviews of cases performed by the former chief of surgery, mentioned previously in this report:

- a VISN review of surgical cases noted in the OMI report as a response to a request from the VA Office of the Secretary due to the former chief of surgery's high complication rate. Per the VCSC's final report of the VISN review, 24 of the 54 cases were sent for further national review (August 2021); and
- a VISN review of 60 surgical cases performed as follow-up to a summary suspension of privileges (June 2022).

The August 2021 national review of 24 cases identified 6 with standard of care concerns regarding pre-operative, peri-operative, and post-operative patient care management. [40]

Upon receipt of the national review, the COS emailed the Facility Director and stated,

> . . . we really have no other reasonable choice at this point but to go above this and remove [the former chief of surgery] from clinical activity based on a continuous threat to patient safety pending a full investigation of the entire report.

In June 2022, the VISN initiated a review in response to the interim COS's concerns that the former chief of surgery's clinical practice did not meet accepted standards and was a potential threat to patient safety. This VISN review identified 10 additional standard of care concerns related to pre-operative, peri-operative, and post-operative patient care management.[41] Interim Facility Director 1 assumed the role shortly after the summary suspension was implemented and was serving in the role when the completed VISN review was discussed at a Clinical Executive Committee meeting in October 2022.

A VISN leader and facility leaders told the OIG that, despite multiple findings of failure to meet the standard of care, SLB reporting had not been initiated. Interim Facility Director 1 and the interim COS told the OIG that reporting would follow the revocation of the former chief of surgery's privileges and a VISN program manager shared that reporting had not started "because it was still in the investigation stage."

Further, on February 3, 2023, the OIG learned from the interim COS that a third VISN review of 273 cases, performed as a result of the OMI recommendation previously discussed in this report, identified 7 cases which did not meet the standard of care. The OIG identified the need for

[40] The OIG was not able to obtain details regarding the decision to send cases for a national review, the case-selection method, or who performed the national review. When asked, the VCSC reported VISN leaders involved in those decisions were no longer in those roles.

[41] The OIG denoted cases as not meeting standard of care if the reviewers used the following terminology, "did not meet standard of care." The OIG identified 10 such cases in this review, whereas the documentation the interim COS provided to the OMI identified 11 cases as not meeting standard of care.

continued VISN oversight to determine if any reporting actions were taken by facility leaders as a result of the clinical reviews.

The OIG found that the 16 cases with standard of care concerns, identified in two clinical reviews conducted prior to this inspection, met the SLB reporting threshold. The OIG concluded that the national and VISN reviews of the former chief of surgery's practice provided evidence that a reasonable person could accept as adequate to support a concern for the safety of facility surgical patients and thus the Facility Director and interim Facility Director 1 each missed an opportunity to initiate the SLB reporting process. The facility was not in compliance with VHA policy, and failed to notify the SLB of the identified concerns in the state(s) in which the former chief of surgery was actively licensed.[42] Based on the two clinical reviews and a third, more recent review reported in February 2023, the OIG identified the need for continued VISN oversight to ensure facility leaders meet SLB reporting requirements.

4. General Surgeon Staffing, Privileging, and On-call Response Times

Physician staffing, privileging, and access to specialist consultation are key components of the infrastructure required for a facility to provide a specific level of care.[43]

The OMI made two recommendations regarding general surgeon staffing and appropriate privileging and on-call schedules.

[42] VHA Directive 1100.18.

[43] VHA Directive 1220(1).

Hiring General Surgery Providers

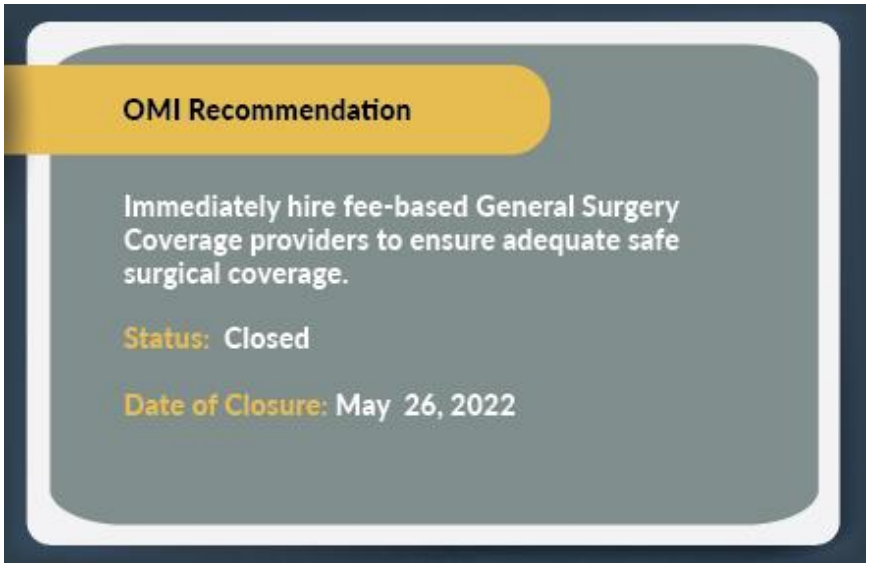

Figure 4. *OMI Recommendation: Hiring General Surgery Providers.*
Source: OMI Report, April 16, 2022, and OMI recommendation status.

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation. The documentation included

- three months of general surgery call schedules, which reflected more equitable distribution of call days among call providers;
- explanation of facility challenges with the hiring of three fee-basis general surgeons;
- the on-boarding of a part-time general surgeon in March 2022; and
- plans to on-board an additional full-time general surgeon on July 1, 2022.[44]

Upon review, the OIG did not identify concerns with the facility leaders' response to the recommendation and determined the facility leaders' corrective actions were sufficient.

[44] VA Handbook 5011/33, *Hours of Duty and Leave*, December 14, 2018. Fee-basis appointments are made when health services are not otherwise available. For example, a general surgeon may be appointed on a fee basis to perform surgeries that cannot be performed by facility general surgeons.

Privileging and On-call Response Times

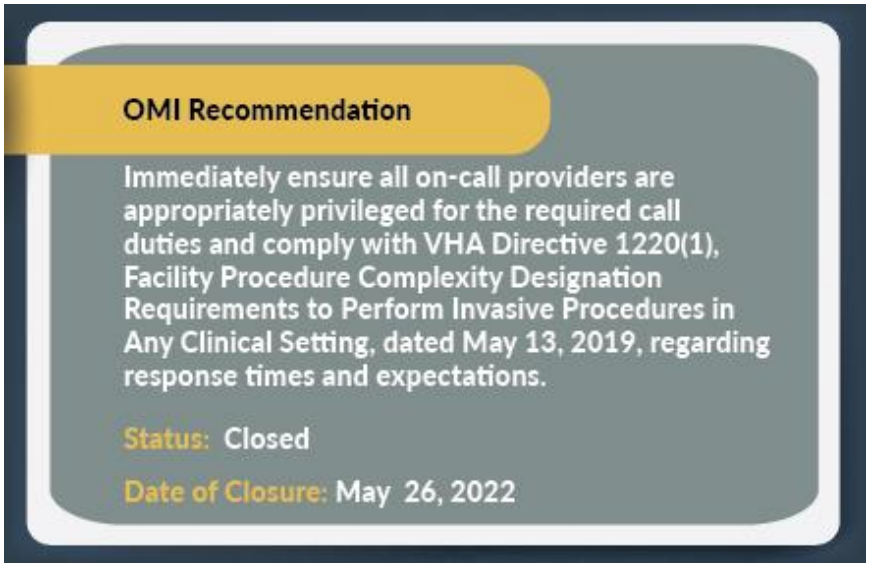

Figure 5. *OMI Recommendation: Privileging and On-call Response Times. Source: OMI Report, April 16, 2022, and OMI recommendation status.*

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation. The documentation included

- blank general surgery, plastic surgery, thoracic surgery, vascular surgery, and orthopedic surgery privileging templates outlining the scope and content of surgical patient care services;
- facility leadership validation that all providers were appropriately privileged for their discipline; and
- facility attestation that surgical service on-call schedules reflected appropriate staffing that "comply with VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting*."[45]

Upon review, the OIG did not identify concerns with the facility leaders' response to the recommendation and determined the facility leaders' corrective actions were sufficient.

[45] VHA Directive 1220(1). VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, amended September 15, 2021. The delineation of a provider's clinical privileges specifies "the scope and content of patient care services" that a provider is approved to perform at a facility.

5. Review of Quality Management Processes

VHA defines quality management as "any activity carried out as a systemic health care review activity. . . for the purpose of improving the quality of medical care."[46] VHA has designated M&M reviews and peer reviews as quality management activities. The OMI made three recommendations regarding quality management activities at the facility. Upon review of the facility leaders' response to these recommendations, the OIG identified two additional concerns.

Timely M&M Meetings and Templated Documentation

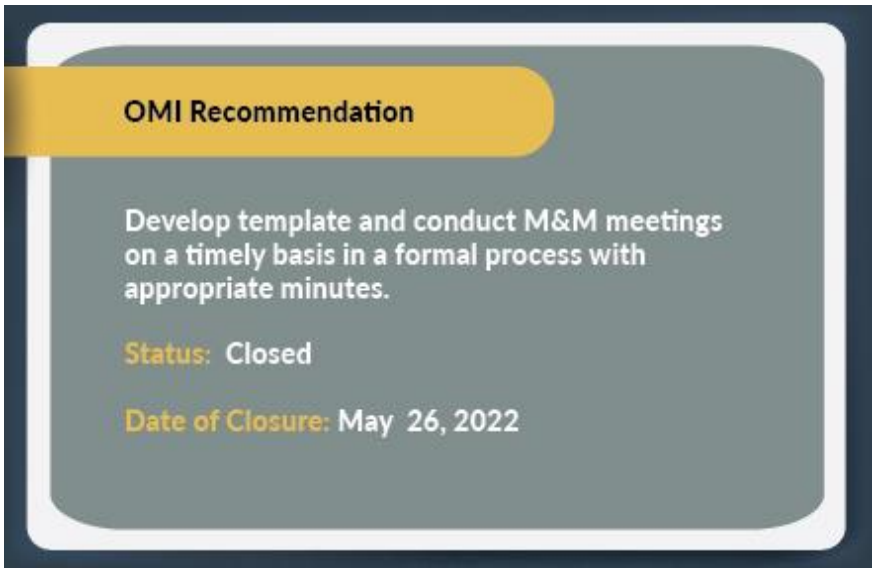

Figure 6. *OMI Recommendation: Timely M&M Meetings and Templated Documentation. Source: OMI Report, April 16, 2022, and OMI recommendation status.*

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation. The documentation included

- interim chief of surgery attendance at five consecutive M&M conferences between September 9 and November 30, 2021; and
- evidence of four M&M conferences between January and March 2022 and associated templated M&M minutes.

Upon review, the OIG found evidence of regular M&M conferences and that associated minutes were templated. However, upon review of the minutes from all M&M conferences conducted

[46] VHA Directive 1320, *Quality Management and Patient Safety Activities that can Generate Confidential Records and Documents*, July 10, 2020. VHA uses the terms "quality management," "quality improvement," and "quality assurance" interchangeably. For purposes of this report, the OIG will use quality management.

during the review period, the OIG identified a concern regarding the interim chief of surgery's facilitation and oversight of M&M conferences.

OIG-Identified Concern Regarding Surgical Service Leader Oversight of M&M Conferences

During the review, the OIG identified a related concern regarding the interim chief of surgery's facilitation and oversight of M&M conferences. Specifically, the OIG found that the interim chief of surgery inconsistently attended and participated in M&M conferences and relied on the surgical quality nurse for planning and facilitating M&M conferences.

VHA defines M&M conferences as "discussions among clinicians of the care provided to individual patients who died or experienced complications." These conferences are used for improving quality of health care in VA medical facilities.[47] VHA designates the chief of surgery as responsible for "facilitating and participating in VA medical facility surgical mortality and morbidity review conferences." The facility surgical quality nurse is also required to participate in M&M conferences.[48] As part of facilitation of M&M conferences, the OIG expects collaboration between the chief of surgery and surgical quality nurse; however, the responsibility falls upon the chief of surgery to facilitate and provide oversight of the M&M conferences.

Upon review, the OIG found that the interim chief of surgery only attended 8 of 14 M&M conferences conducted during the review period.[49] The interim chief of surgery also denied facilitating the conferences, and deferred this task to the surgical quality nurse. The surgical quality nurse reported the previous COS placed the responsibility for ensuring continuation of surgical meetings, such as M&M conferences, on the surgical quality nurse rather than on the interim chief of surgery.

While the responsibility for facilitation of M&M conferences lies with the chief of surgery, per VHA policy, the OIG found in practice the surgical quality nurse ensured M&M conferences continued. VHA policy requires the chief of surgery, even in an interim capacity, to facilitate and provide oversight of M&M conferences according to VHA policy.[50]

[47] VHA Directive 1320.

[48] VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

[49] The OIG reviewed 15 sets of M&M conference minutes within the 13-month review period, this was due to M&M conferences being held multiples times within 5 different months and 4 months with no M&M conferences held. Only 14 of those minutes included a list of attendees.

[50] VHA Directive 1102.01(2).

Peer Review Committee Minutes

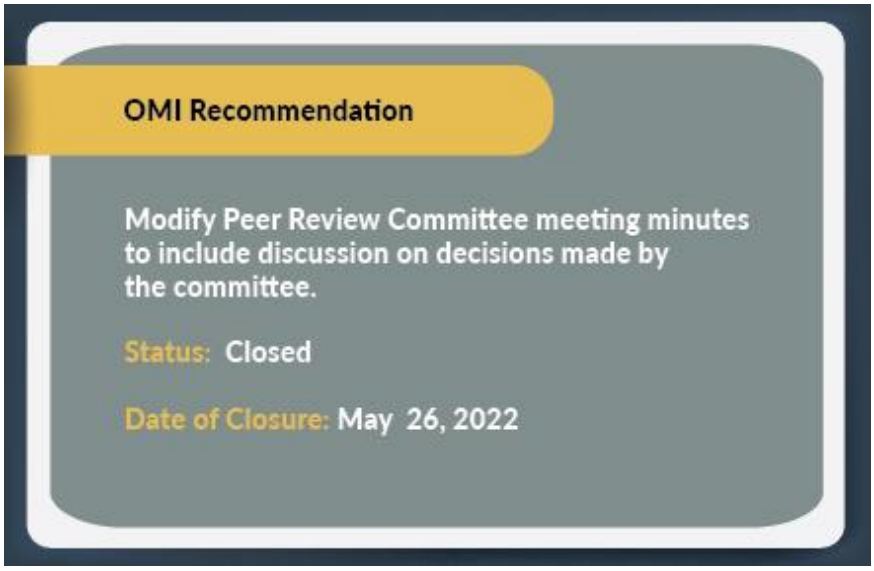

Figure 7. *OMI Recommendation: Peer Review Committee Minutes.*
Source: OMI Report, April 16, 2022, and OMI recommendation status.

The OIG reviewed documentation facility leaders provided the OMI to close the recommendation. This documentation included evidence of five sets of templated Peer Review Committee minutes that documented the committee's discussions and decisions.[51]

Upon review of the minutes from all Peer Review Committee meetings conducted during the review period, the OIG found that quality management leaders had improved the quality of the documentation of discussions and decisions in the Peer Review Committee. The OIG did not identify any additional concerns.

[51] VHA Directive 1190. Peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both "short-term and long-term improvements in patient care." Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.

VHA Clinical Risk Management Consultation

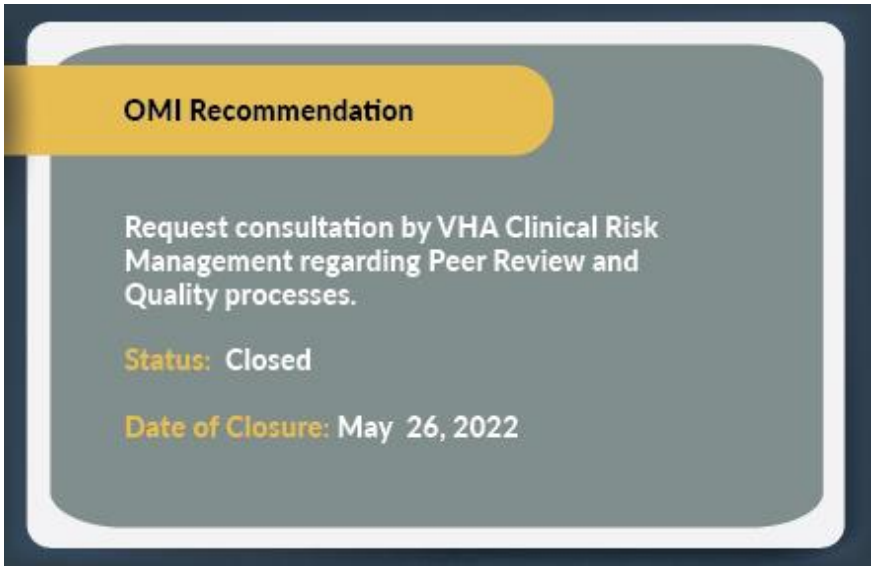

Figure 8. *OMI Recommendation: VHA Clinical Risk Management Consultation. Source: OMI Report, April 16, 2022, and OMI recommendation status.*

The OIG reviewed documentation facility leaders provided the OMI to close the recommendation. This documentation included evidence of VHA Clinical Risk Management guidance regarding documentation of Peer Review Committee meeting minutes as well as guidance regarding the process for neutral review of Peer Review Committee members under review.

Upon review, the OIG did not identify concerns with the facility leaders' response to the recommendation and determined the facility leaders' corrective actions were sufficient.

Peer Reviews of the Provision of Care by Peer Review Committee Members

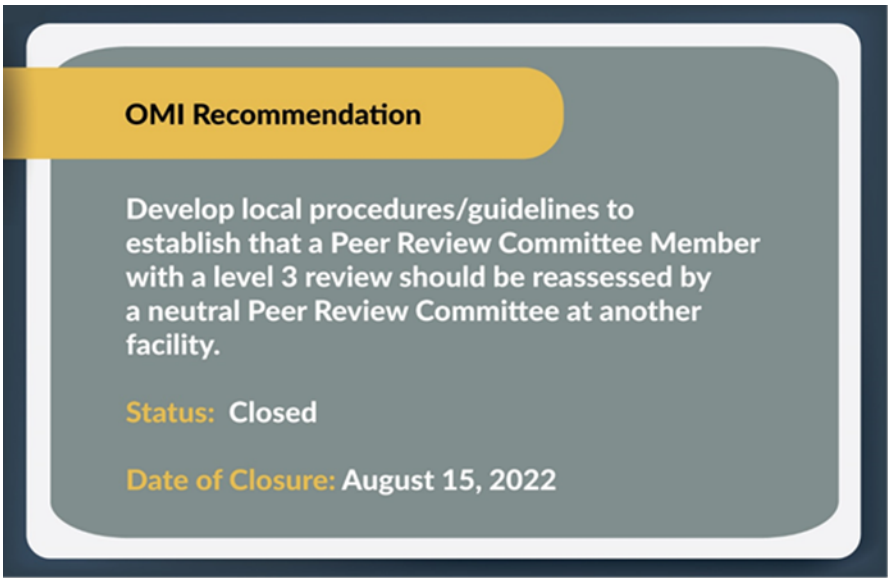

Figure 9. *OMI Recommendation: Peer Reviews of Peer Review Committee Members. Source: OMI Report, April 16, 2022, and OMI recommendation status.*

The OIG reviewed documentation facility leaders provided the OMI to close this recommendation. The documentation included

- evidence of VISN 10 risk management officer and facility risk manager consultation;
- facility risk manager's development of process to send to another facility those peer reviews when the provider is on the Peer Review Committee; and
- minutes documenting discussion of new Peer Review Committee member peer review process at the June 2022 Peer Review Committee meeting.

Upon review, the OIG found a deficiency in the facility leaders' corrective action plan.

OIG-Identified Concern Regarding Reviews of Peer Review Committee Members' Care

During this review, the OIG identified a concern that the lack of neutral, final level designation of Peer Review Committee members' peer reviews may compromise the peer review process. The OIG found that facility leaders changed the process of review for those peer reviews in which the provider is on the Peer Review Committee, specifically requiring an initial, neutral party, review each case. However, the OIG noted that the process did not include a neutral party conducting a final review of Peer Review Committee member's cases.

During the inspection, the OIG reviewed the report of facility leaders' consultation with VHA Medical-Legal Risk Management staff as well as written guidelines developed by quality management leaders to address the neutral reassessment of Peer Review Committee members with a level 3 review result.[52] As background, the OMI made this recommendation in response to an allegation of facility leaders' manipulation of the peer review process.

The VISN QMO told the OIG that facility and VISN leaders consulted with the VHA Medical-Legal Risk Management Director in May 2022.[53] The VISN QMO told the OIG the consultation resulted in recommendations, which included that initial peer reviews for "peer review committee members should be sent for review by another facility."

The OIG learned during interviews that, in response to the OMI recommendation and VHA guidance, facility practice was changed to ensure all initial peer reviews for committee members were sent for outside review. The risk manager also provided the OIG with a "Job Instruction Sheet" for Peer Review Committee members, which was developed in July 2022. Upon review, the OIG found the "Job Instruction Sheet" indicated all initial reviews of Peer Review Committee members must be sent for external review but did not address the OMI's recommendation that reviews of Peer Review Committee members with an initial level 3 rating be "reassessed by a neutral Peer Review Committee at another facility."

The OIG is concerned that, although quality management leaders developed a process for external initial reviews of Peer Review Committee members, this corrective action does not ensure the integrity of a final level peer review designation as the facility Peer Review Committee, not a neutral reviewer, makes the final level determination.

6. Review of VISN Oversight and Support—General Surgery and COS

The OMI made one recommendation regarding VISN 10's leadership support to facility general surgeons and the COS. During a broader review of VISN 10 oversight of, and support provided to, the facility, the OIG identified two concerns—VISN Academic Affiliations Program oversight and the VISN surgical workgroup oversight.

[52] VHA Directive 1190. "Level 1 is the level at which experienced and competent clinicians would have managed the case in a similar manner. Level 2 is the level at which most experienced and competent clinicians might have managed the case differently but remains within the standard of care. Level 3 is the level at which experienced and competent clinicians would have managed the case differently."

[53] The VISN QMO told the OIG that other VHA leaders on the consultative call included the NSO Director, Medical-Legal Risk Management Director, and Medical Staff Affairs Director. VISN and facility leaders were also in attendance.

Facility Leadership Support

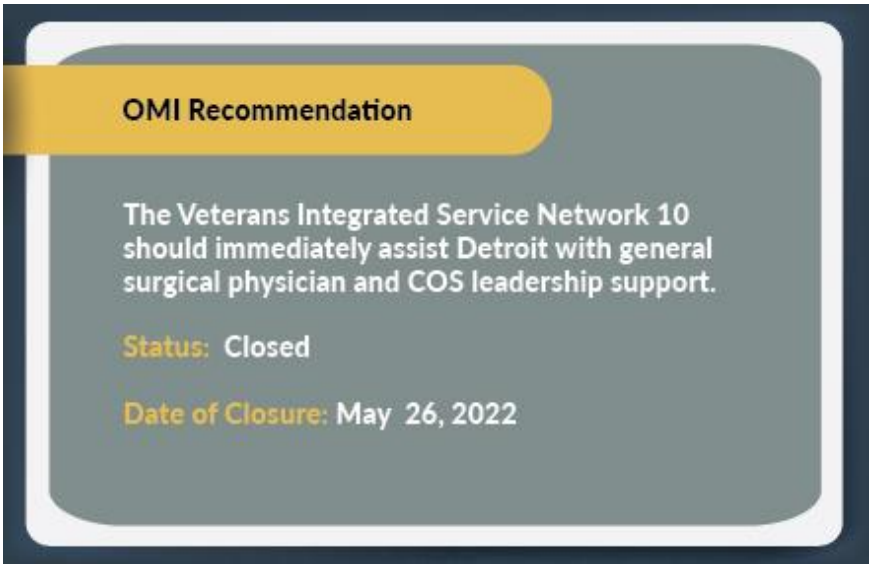

Figure 10. *OMI Recommendation: Facility Leadership Support.*
Source: OMI Report, April 16, 2022, and OMI recommendation status.

The OIG reviewed documentation facility leaders provided the OMI to close the recommendation. This documentation included evidence of

- facility collaboration with the VISN 10 VCSC;
- the assignment of an interim COS; and
- CMO support to identify an interim chief of surgery and documentation that a facility provider had assumed the interim chief of surgery position.[54]

Upon review, the OIG found that the CMO and VCSC provided support to the facility's general surgery department and COS; however, the OIG identified two additional concerns. Specifically, the OIG found that the VISN academic affiliations officer was not aware of the OMI recommendation related to resident supervision and did not provide oversight to the facility's surgical residency program. Further, the VCSC and VISN surgical workgroup did not ensure oversight per VHA policy.

[54] The OIG received documentation indicating the interim chief of surgery position was filled in December 2021.

OIG-Identified Concern Regarding VISN Academic Affiliations Program Oversight

The OIG identified a concern regarding the VISN academic affiliations officer's lack of oversight and support to ensure compliance with VHA policy.[55] Further, the OIG identified an instance of siloed communication within the VISN as the CMO did not inform the VISN academic affiliations officer of the general surgery residency concerns identified by the OMI, nor was the academic affiliations officer aware of any concerns regarding the direct supervision of general surgery residents at the facility.

Per VHA policy, the VISN academic affiliations officer is responsible for "ensuring that all VA medical facilities comply with the contents of [VHA Directive 1400.01] and have a robust local monitoring program."[56] According to the memorandum of understanding between the VISN Director and the person appointed to the VISN academic officer role, the assignment was a collateral duty and the position administratively reported to the CMO. The memorandum acknowledged that the VISN academic affiliations officer remained an employee of another VISN 10 facility as well as "a representative of VISN 10 as a collateral duty" and stated that "while you serve in this capacity, one role does not override or supersede the other."[57] The memorandum outlined responsibilities including

- "providing leadership and guidance for the network [VISN 10];"
- "maintain awareness and oversight of facility level activities;" and
- "respond to allegations of non-compliance."

The VISN academic affiliations officer reported being in the position "between five to six years" and described routine position duties as including chairing a VISN committee and workgroup and serving as a resource for other education officers "unless the VISN asked me specifically to ask for information or to do something. . . ." The VISN academic affiliations officer reported no awareness of the OMI report or recommendations regarding the facility's general surgery residency program and denied having any involvement with, or oversight of, the residency program at the facility. When asked of involvement regarding facility leaders' corrective actions, the VISN academic affiliations officer replied

> No, unless the VISN specifically would ask me to get involved. . . I've had no knowledge of what's been happening at Detroit. Their [the facility's] DEO

[55] VHA Directive 1400.01. The VISN 10 academic affiliations lead is referred to as the VISN academic affiliations officer throughout this report.

[56] VHA Directive 1400.01.

[57] The VISN academic affiliations officer is a physician employed at another VISN 10 facility.

> [designated education officer] has not talked to me. . . the VISN has not reached out to me for any involvement.

When asked if it would be appropriate for a facility to request VISN academic affiliations officer assistance with concerns or compliance issues with a facility residency program in the VISN, the academic affiliations officer replied "Yes. If somebody asked me to review it, but I have. . . no way of knowing that someone has a problem unless someone brings it to my attention."

The CMO, who functions as administrative supervisor of the VISN academic affiliations officer, reported intermittently working with the VISN academic affiliations officer, but was unaware of specific position description requirements or collateral duty status related to the position. The OIG expects the CMO to provide oversight to the VISN academic affiliations officer as outlined in the memorandum of understanding, to include ensuring the officer is aware of compliance issues identified at VISN facilities.

The OIG found the VISN academic affiliations officer did not provide proactive oversight of the facility's residency activities or respond to allegations of non-compliance as outlined within the position's memorandum of understanding. Further, the OIG found this position lacked substantive oversight as outlined in VHA policy.[58] The OIG is concerned that according to the VISN academic affiliations officer, neither the VISN nor the facility informed the VISN academic affiliations officer of the facility's non-compliance with VHA policy given they are responsible for compliance.[59] Lastly, the OIG expects the CMO to provide oversight to the VISN academic affiliations officer as outlined in the memorandum of understanding to include ensuring awareness of compliance issues identified at VISN facilities.

OIG-Identified Concern Regarding Oversight by the VISN Surgical Workgroup

The OIG identified a concern regarding the oversight provided through the VISN surgical workgroup; specifically, the lack of documentation of VISN surgical workgroup discussions.

The VCSC's major duties include monitoring and promoting "compliance with VA regulations and professional standards. . . ensuring that current Surgery practices across the VISN are in compliance with VHA policy," and overseeing and addressing "any deficiencies in VISN clinical outcomes and standards of care." NSO guidelines outline the VCSC's responsibilities to include oversight of clinical outcomes, standard of care, and "confirmation that current surgical practice across the VISN is in compliance with VHA Directives and Policy."[60] Another responsibility of

[58] VHA Directive 1400.01.

[59] VHA Directive 1400.01.

[60] "VISN Chief Surgical Consultant" (website), VHA National Surgery Office, accessed October 6, 2022, https://dvagov.sharepoint.com/sites/VHANSO/SitePages/VISN-Chief-Surgical-Consultant.aspx. (This website is not publicly accessible.)

the VCSC is to chair the VISN surgical workgroup, which ensures compliance with surgical complexity requirements and oversees "compliance with VHA surgical and related policy across the VISN." VHA also requires the surgical workgroup to monitor "performance improvement activities within the VISN to ensure systems issues are addressed."[61]

The OIG found the VCSC provided additional support to facility surgical leaders in response to the OMI recommendations. The VCSC, who reported being in the role three to four years at the time of the inspection, told the OIG of allocating approximately 50 percent of time as the chief of surgery at another VISN 10 facility and dedicating the other 50 percent of time to VISN activities. The OIG learned the VCSC provided facility oversight through monthly VISN workgroups and quarterly meetings with leaders from each VISN facility but had not conducted site visits to the facility during 2020 and 2021 due to COVID restrictions. The VCSC further reported that on-site visits to review the surgery service had resumed, and a February 2022 site visit to the facility had resulted in the VCSC's recommendations to increase the number of providers and staff as well as administrative support such as a residency site coordinator.

The VCSC reported meeting with the interim COS regularly and conducted an additional site visit to the facility in July 2022. The VCSC reported being available for additional consultation as needed. In addition, the VCSC mentioned the development of a resource book and a potential training opportunity for new facility chiefs of surgery.

The OIG reviewed VISN 10 surgical workgroup meeting minutes held during the inspection period and found that a majority of the meetings referenced VHA policies; however, these discussions did not capture any discussion regarding facility compliance with the policies reviewed. The VCSC reported that as part of the workgroup's review of surgical complexity requirements, each VISN facility provides a monthly report, which provides the status of vacant surgical positions. However, upon OIG's review of the VISN surgical workgroup minutes, there is no related discussion regarding how the vacancies impact the facility's surgical complexity level or actions taken to bring the facility into compliance.[62] A review of the facility's monthly reports to the VISN surgical workgroup showed the facility did not provide the status of the vacant chief of surgery position or acknowledge the OMI recommendations. The OIG expects the VISN surgical workgroup would be a forum for discussion of these actions as there may be application to other VISN facilities and directly address VHA policy compliance.

The OIG found that the VCSC was responsive to VISN and facility leaders' requests to review the former chief of surgery's clinical care, conducted on-site visits to the facility, and had regular contact with the COS. However, the OIG expects VISN surgical workgroup oversight to include not just a report of information and status, but discussions about the impact of the information,

[61] VHA Directive 1102.01(2).

[62] Per a VISN representative, the facility was not required to provide the VISN with a monthly report; the facility provided a quarterly "VISN 10 NSO Report Metric Action Plan."

which would be a forum for other VISN facilities to review similar concerns respectively. The OIG found that the VISN surgical workgroup did not document vital information from the facility, which could have ramifications across other facilities within the VISN as well.

7. OIG-Identified Concern Regarding Instability in Facility Leadership

The OIG found that from November 2021 through January 2023, three of five executive leaders at the facility were serving in an interim capacity.[63] The OIG is concerned that the facility leaders' corrective actions in response to the OMI recommendations may not be sustainable due to frequent changes to key facility leadership positions (see table 2). The OIG has identified in other reports that frequent turnover, vacancies, and long-term use of leaders in interim positions have significant negative consequences for facilities.[64] The OIG found that VISN executive leaders actively engaged and supported facility leaders through a period of leadership transition in January 2023, and expects that this support will continue through ongoing transitions until permanent leadership is in place.

Table 2. Leadership Changes

	August 2021	September - October 2021	November - December 2021	January - February 2022	March - April 2022	May - June 2022	July - August 2022	September - October 2022	November - December 2022	January 2023
Facility Director	Permanent #1						Interim #1			Interim #2
Associate Director for Patient Care Services	Permanent #1					Interim #1	Interim #2			Interim #3
Chief of Staff	Permanent #1			Interim #1	Interim #2					
Chief of Surgery	Permanent #1	Interim #1			Interim #2		Interim #3			Permanent #2

Source: Dates of those serving in interim leadership roles provided by VISN and facility quality, safety, and value staff, during interviews with VISN and facility leaders; and documentation of personnel actions.

Between December 2021 through January 2023, interim facility leadership included the Director; COS; Associate Director for Patient Care Services; chief of surgery; and the chief of quality, safety, and value. Each of these positions had a role in the facility leaders' corrective actions in

[63] VA Handbook 5005, *Staffing*, April 15, 2002. "If a replacement is required while the incumbent is on extended leave, an interim position may be established. Generally, interim positions will be terminated within 1 year or less."

[64] VA OIG, *Comprehensive Healthcare Inspection of Veterans Integrated Service Network 5: VA Capitol Health Care Network in Linthicum, Maryland*, Report No. 21-00239-180, July 14, 2022. VA OIG, *Descriptive Analysis of Select Performance Indicators at Two Healthcare Facilities in the Same Veterans Integrated Service Network*, Report No. 20-02899-22, November 16, 2021. VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-00497-161, July 11, 2019.

response to the OMI recommendations and VISN site visit recommendations.

During the inspection, the OIG learned of further leadership changes at the facility happening in January 2023 (see table 2). The VISN Director told the OIG that interim Facility Director 2 just completed a director training program through the VHA Midwest Consortium, and would only hold the position for a total of 70 days as the VISN Director worked toward getting an interim leader for a longer assignment.[65] Further, the VISN Director told the OIG of the intent to announce a "not to exceed a year" interim Facility Director position but acknowledged that there were challenges as the Facility Director was still occupying the position with an unknown disposition.[66]

The VISN Director told the OIG that the interim facility leaders were "a little on edge;" subsequently, the VISN Director recognized the need for additional support. In January 2023, the VISN Director implemented a plan that included a schedule of weekly VISN executive leadership visits to the facility to increase visibility during upcoming leadership changeover.[67] The plan stated,

> Given the instability of Detroit leadership and vulnerabilities identified over the last year, providing additional VISN oversight during this transition is necessary to ensure optimal functioning of the health care system and sustainment of the actions identified over the last 6 months. VISN ELT [executive leadership team] will attend executive huddles and meetings. . . to observe, coach and mentor ELT and others as needed. In addition, the ELT will be visible to both leadership and front-line staff at. . . the medical center.

The interim COS told the OIG that a permanent chief of surgery had been selected, and the OIG confirmed the selectee was in the position in January 2023. The interim COS also told the OIG that a selection had been made for the newly created deputy chief of surgery position.

The OIG found that VISN executive leadership recognized the facility was vulnerable during times of leadership transition. Further, the OIG found that VISN executive leaders were

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[65] Hearing on Building a More Resilient VA Supply Chain, *Before the Senate Committee on Veterans' Affairs*, 116th Cong. (June 9, 2020) (statement of Richard A. Stone, M.D., Executive in Charge, Veterans Health Administration, Department of Veterans Affairs). "A VISN Consortium is a partnership between multiple VISNs located in the same region of the country. VISNs formed consortiums to foster collaboration among medical centers and to enhance operations and the delivery of health care to Veterans."

[66] The Facility Director began a detail to a position in VA Central Office in July 2022.

[67] Network Director, Veterans Integrated Service Network 10 (10N10), "Plan for increased Veterans Integrated Service Network 10 Executive Leadership Team Visibility at Detroit during leadership changeover," memorandum to the Deputy Network Director, Veterans Integrated Service Network 10 (10N10), Chief Medical Officer, Veterans Integrated Service Network 10 (10N10), Chief Nursing Officer, Veterans Integrated Service Network 10 (10N10), Quality Management Officer, Veterans Integrated Service Network 10 (10N10), December 2, 2022. The CMO provided the OIG a schedule that indicated VISN executive leaders would rotate to ensure weekly VISN executive leadership presence at the facility from January 3 through March 10, 2023.

committed to supporting the facility through these transitions to ensure the sustainability of corrective actions and facilitate ongoing leadership transitions.

8. Impact of Facility Leaders' Actions on HRO Principles

During the inspection, the OIG identified concerns surrounding past facility leaders'

- siloed communication,
- lack of governance and policy management, and
- failure to create a psychologically safe environment.

The OIG found that these deficiencies were not consistent with HRO goals.[68]

The OIG also found that since July 2022, interim facility leaders had instituted several HRO initiatives aimed at improving communication, establishing governance policy, and increasing psychological safety. However, the OIG is concerned that if previous leaders return, or temporary leaders have short assignment periods, the facility could lose any forward progress made toward HRO goals.

Communication Silos

Leadership behaviors that cultivate an HRO include a nurturing environment that builds trust by supporting communication across organizational lines and services.[69] VHA HRO guidance states "to achieve optimal effectiveness. . . communication must be bi-directional and instill continuous feedback loops."[70]

The VISN Director described previous facility leadership as having had "siloed communication routes" where "there was not a lot of cross communication across services." The VISN QMO indicated concerns that the previous Facility Director attempted to manage the OMI report recommendations with a small group, which limited transparency and the ability to discuss corrective actions.[71] The VISN QMO explained that it was "very hush, hush at Detroit. . . there were only certain people that you could talk to, which was the director and. . . the [interim] chief of staff. . . it wasn't like they were inclusive of quality [safety, value service]." Further, the

[68] *VHA Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, March 24, 2022. The three pillars of an HRO are leadership commitment, safety culture, and continuous process improvement. In addition to the three pillars, HRO is also defined by five principles (Sensitivity to Operations, Preoccupation with Failure, Reluctance to Simplify, Commitment to Resilience, and Deference to Expertise) and seven values (It's About the Veteran, Support a Culture of Safety, Commit to Zero Harm, Learn, Inquire and Improve, Duty to Speak Up, Respect for People, and Clear Communications).

[69] VHA Leader's Guide to Foundational High Reliability Organization (HRO) Practices.

[70] VHA Leader's Guide to Foundational High Reliability Organization (HRO) Practices.

[71] The VISN QMO identified the previous Facility Director and the interim Chief of Staff as part of the "small group" but was unable to identify others involved.

interim chief of surgery and the interim chief of quality, safety, and value told the OIG of limited knowledge of the OMI findings and recommendations as facility leaders did not provide them a complete copy of the report.

After a June 2022 site visit, the VISN Chief Nursing Officer recommended facility leaders improve communication as "there is an opportunity to be sensitive to operations, engaging nurse leaders and front-line staff in their work area changes." The VISN Chief Nursing Officer also documented that "It was stated that information does not trickle down the way it is supposed to be." VISN leaders closed this recommendation in November 2022 after facility leaders provided information regarding town halls, integration of clinical nurse managers in nursing leadership meetings, and the VISN Chief Nursing Officer reported receiving positive feedback from facility staff during a VISN follow-up visit in September.

Interim Facility Director 1 and the VISN Director told the OIG that communication changes made by interim leaders were well-received by facility staff. Interim Facility Director 1 told the OIG of implementation of facility-wide daily safety huddles where employees could share concerns and could offer potential resolutions. Interim Facility Director 1 also told the OIG that multiple town halls were conducted with employees and supervisors, where concerns were shared with responsible parties. When reflecting on challenges encountered at the facility, the VISN Director stated "[It's going to] take time, but it needs the right leader and it needs some permanent leadership in those roles. . . it's going to be some time before we get those."

While the OIG did not expect widespread dissemination of the OMI report, the OIG expected those in leadership roles, such as the interim chief of surgery and the interim chief of quality, safety, and value, would have been provided the report and had knowledge of the report's findings and recommendations as both positions were responsible for corrective actions recommended in the report. Though the OIG noted interim facility leaders' reduced communication silos with facility staff, the OIG is concerned that the changes may not be sustainable due to the temporary nature of facility leader assignments.

Lack of Governance and Policy Management

In 2015, the Government Accountability Office cited "Ambiguous VA policies lead to inconsistency in the way VA facilities carry out processes at the local level. . . [and] may pose risks for veterans access to VA health care, or for the quality and safety of VA health care."[72] While not a formal part of HRO, VHA mandated that facilities use standardized templates for local medical center policies and standardized operating procedures; respectively, these documents govern practice and responsibilities, and detail steps and activities related to a process or procedure. VHA also mandates facilities use charters to outline responsibilities and functions

[72] GAO, *High Risk Series, An Update*, GAO-15-290, February 2015.

of a standing group.[73] Further, medical center policies "must be recertified no later than 5 years after publications."[74]

During a June 2022 site visit, the VISN Chief Nursing Officer recommended facility leader update the committee structure and the lack of action tracking for Patient Care Services Executive Staff Committee minutes. The VISN Chief Nursing Officer recommended updates to the committee structure and a plan to improve minutes.[75]

Interim Facility Director 1 told the OIG of identifying concerns regarding the facility's lack of formalized governance processes upon arrival at the facility in July 2022. To address this concern, in November 2022, interim Facility Director 1 published a medical center policy that outlined facility governance and set expectations for facility leadership and culture for the facility. This policy defined the reporting structure for boards and committees, explained committee chair and members' responsibilities, and provided templates for committee documentation.[76] Interim Facility Director 1 also reported providing training to employees regarding the use of standardized templates for committee agendas and minutes.

While the OIG did not review all facility policies, during the inspection the OIG noted that facility leaders had not recertified or revised facility policies related to peer review, credentialing, verification of licensure, and disciplinary actions in over five years. These policies were not in compliance with the VHA directive on policy management.[77] The OIG also found quality, safety, and value, and surgical service leaders had not used charters to establish and outline the responsibilities and functions for the facility Peer Review Committee processes or facility M&M conferences. Subsequently, this committee and conference were not in compliance with the VHA directive.[78]

However, the OIG found interim leaders made improvements that demonstrated commitment to HRO principles, including changes to the facility's peer review case selection process. Although the OMI report did not make recommendations regarding how quality management leaders select cases for peer review, the facility risk manager told the OIG that previous practice involved a "pre-review" by the COS prior to Peer Review Committee assignment. The risk manager told the

[73] "Merriam-Webster.com Dictionary, "governance," accessed February 23, 2023, https://www.merriam-webster.com/dictionary/governance. The act or process of governing or overseeing the control and direction of something (such as a country or an organization). VHA Directive 0999, *VHA Policy Management*, March 29, 2022.

[74] VHA Directive 0999.

[75] These recommendations remained open as of January 2023.

[76] Medical Center Policy 00-001, *Governance, Leadership, and Culture*, November 1, 2022.

[77] VHA Directive 0999.

[78] VHA Directive 0999. Charters establish "and outlines the responsibilities and function of a committee, council. . . or equivalent type of standing group," and VHA's charter template includes group membership, and frequency of meetings. The OIG did learn that quality management staff were assisting in the development of a charter for the Peer Review Committee; however, interim Facility Director 1 had not signed the charter as of December 2022.

OIG that, after consulting with the VISN risk manager, the facility discontinued COS "pre-review" of peer review cases.

The OIG found that, while interim facility leaders demonstrated a commitment to HRO principles through development of a governance, leadership, and culture policy to support transparency, the OIG noted these changes were new at the time of inspection. The OIG concluded that the facility should continue progress toward establishing governance and policy to support transparency and facilitate leadership transitions. The OIG recognizes that the progression of governance and policy management will challenge incoming interim leaders. Therefore, sustainability, and continuation of the facility's HRO efforts, requires ongoing VISN oversight and support.

Psychological Safety

Leadership behaviors that cultivate an HRO include a nurturing environment that builds trust by creating psychologically safe venues where staff are comfortable voicing opinions. Research describes psychological safety as "a feeling that individuals are comfortable expressing and being themselves, as well as comfortable sharing concerns and mistakes without fear of embarrassment, shame, ridicule, or retribution."[79]

The CMO told the OIG of historical concerns regarding lack of psychological safety and stated,

> Drawing conclusions now. . . there was a pervasive attitude that employees were afraid to speak up; that made it quite challenging. . . [it] was pervasive in Detroit. Many of the services felt. . . that they could not express complaints to leadership.

During a June 2022 site visit, the VISN Chief Nursing Officer documented concerns regarding psychological safety at the facility and subsequently made a recommendation for improvement. In response, facility leaders developed corrective actions, including the creation of an "employee suggestion box" on an internal SharePoint site where questions and suggestions are submitted by employees and then reportedly reviewed weekly by executive leaders and the HRO facility lead. Other corrective actions included the implementation of a mobile rounding application to increase the visibility and accessibility of facility leaders to front-line staff. Two recommendations related to psychological safety and leadership rounding remained open as of January 2023.

A June 2022 quality management site visit also recommended the facility establish a facility HRO lead position. The interim chief of quality, safety, and value told the OIG that the facility hired a facility HRO lead in September 2022. The OIG found that the HRO lead began attending

[79] Karina D. Torralba , Donna Jose, and John Byrne, "Psychological safety, the hidden curriculum, and ambiguity in medicine," *Clinical Rheumatology* 39, (January 4, 2020): 667-671, https://doi.org/10.1007/s10067-019-04889-4.

the Peer Review Committee meetings in October 2022, and the facility risk manager told the OIG that the committee had become more psychologically safe.

When asked if progress with reporting concerns at the facility was sustainable, the CMO replied affirmatively, stating "I do because I think the veil has been lifted."

The OIG concluded that interim facility leaders had made efforts, including the creation of a SharePoint site for anonymous submission of concerns and leadership rounding, to improve psychological safety at the facility. The OIG expects facility and service leaders to continue efforts to create and promote a psychologically safe environment and that VISN support and oversight will be necessary to sustain progress in the facility's unstable leadership environment.

9. VISN Leaders' Ongoing Oversight and Support

The OIG evaluated VISN leaders' oversight and interviewed select VISN leaders and the VCSC to identify actions taken to ensure facility leaders had the tools and support necessary to implement sustainable solutions to the OMI-identified concerns. The OIG found that, through site visits related to the OMI recommendations, VISN leaders identified further concerns and addressed those concerns promptly. However, the OIG concluded that continued support is necessary as the executive leadership roles at the facility are unstable and in transition due to pending administrative investigations.

The OIG found that the two-month delay between interim Facility Director 1's recommendation to revoke the former chief of surgery's clinical privileges and the second recommendation to revoke the former chief of surgery's clinical privileges, made in January 2023, was a missed opportunity for additional VISN oversight and support. The OIG would have expected VISN leaders to ensure the completion of interim Facility Director 1's actions related to the recommendation of revocation of the former chief of surgery's clinical privileges as well as ensuring that NPDB and SLB reporting occurred. VISN support is also critical to ensure sustainability of corrective actions taken to address the OMI recommendations and ensure a comprehensive and sustainable response to the recommendations noted in the NSO memorandum.[80]

When asked why VISN leaders were not aware of the above noted facility issues prior to the OMI report, the VISN Director told the OIG that clinical care metrics did not trigger reviews under the previous leadership and there were not "a lot of patient complaints" made to the VISN. The OIG found that VISN leaders' actions were responsive to multiple investigations or reviews around the former chief of surgery's care and leadership style. The interim COS reported satisfaction with support from the VISN, including multiple VISN site visits to the facility, to

[80] NSO National Director of Surgery, "Program Review, John D. Dingell VA Medical Center Surgery Program," memorandum to the Acting Director, John D. Dingell VA Medical Center, March 20, 2023.

address issues such as psychological safety and communication with leaders at the facility in addition to the surgery service.

The OIG found VISN leaders demonstrated commitment to enhanced oversight during current and upcoming facility leadership transitions. However, the OIG is concerned that the recommendation to revoke privileges and subsequently report the former chief of surgery to external entities was delayed during a recent facility leadership transition in December 2022 and January 2023 suggesting opportunities for improvement in communication during periods of transition. On December 2, 2022, the VISN Director issued a memo to the VISN executive leadership team to plan for increased visibility during facility leadership transitions. The memo noted, "[g]iven the instability of Detroit leadership and vulnerabilities identified over the last year, providing additional VISN oversight during this transition is necessary to ensure optimal functioning of the health care system and sustainment of the actions identified over the last 6 months."[81]

Conclusion

The OIG reviewed the OMI report and corrective action plans, which included documents and narrative statements submitted in response to the OMI recommendations. Generally, the OIG found VHA responses sufficient to address the elements of the OMI recommendations.

Facility leaders' corrective actions were responsive to the OMI recommendation regarding reviewing requirements for supervision of residents; however, facility leaders did not meet VHA requirements related to the supervision of PGY-1 residents. When notified of this concern, facility leaders took immediate steps to ensure compliance. Further, upon the VCSC's review of general surgery resident supervision throughout the VISN, and the identification of an additional non-compliant facility, sufficient corrective actions were taken to ensure compliance.

The OIG found that in response to an OMI recommendation, facility leaders initiated a retrospective case review of cases performed by the former chief of surgery. OMI closed the recommendation based on completion of the retrospective review and an NSO surgical program consultation. In March 2023, the NSO issued a memorandum documenting a program review of the facility surgery service. The OIG identified the need for facility leaders to ensure a comprehensive and sustainable response to the recommendations noted in the NSO memorandum.

[81] Network Director, Veterans Integrated Service Network 10 (10N10), "Plan for increased Veterans Integrated Service Network 10 Executive Leadership Team Visibility at Detroit during leadership changeover," memorandum to the Deputy Network Director, Veterans Integrated Service Network 10 (10N10), Chief Medical Officer, Veterans Integrated Service Network 10 (10N10), Chief Nursing Officer, Veterans Integrated Service Network 10 (10N10), Quality Management Officer, Veterans Integrated Service Network 10 (10N10), December 2, 2022. The plan includes increased direct on-site availability, monitoring of facility action plans, and attendance at executive huddles.

Upon review of the facility leader's response to the OMI recommendation regarding NPDB reporting, the OIG identified two additional concerns related to the delay of a proposed privileging action and missed opportunities for SLB reporting. The OIG opined that the two-month processing delay on a final adverse clinical privilege action, reportable to the NPDB, undermined the intent of NPDB reporting, which is meant to prevent providers from being able to move to different employment without disclosure of incompetent performance. The reporting delay is also an example of siloed communication and is an opportunity for additional VISN oversight, intervention, and support.

National and VISN reviews of the former chief of surgery's practice provided evidence that a reasonable person could accept as adequate to support a concern for safety of VA surgical patients and thus the Facility Director and interim Facility Director 1 each missed an opportunity to initiate the SLB reporting process. The facility was not in compliance with VHA policy, and more importantly, facility leaders failed to notify the SLB in the state(s) in which the former chief of surgery was actively licensed, of the identified care concerns.

There were no concerns identified with the facility leaders' response to the recommendation regarding hiring fee-based general surgery providers as the facility leaders' corrective actions were sufficient.

No concerns were identified with facility leaders' response to the OMI recommendation regarding ensuring all on-call providers are appropriately privileged for the required call duties and determined the facility leaders' corrective actions were sufficient.

Upon review of facility leaders' response to the OMI recommendation related to M&M conferences, there was evidence of regular conferences and associated minutes were templated. However, the interim chief of surgery's facilitation of the M&M conferences was inconsistent. Per VHA policy, the responsibility for facilitation of M&M conferences lies with the chief of surgery; however, in practice the surgical quality nurse ensured M&M conferences continued. VHA policy requires the chief of surgery, even if serving in an interim capacity, to facilitate and provide oversight of M&M conferences according to VHA policy.

Quality management leaders had improved the quality of the documentation of discussions and decisions in the Peer Review Committee as recommended by the OMI. The OIG identified no additional concerns.

Upon review, no concerns were identified with facility leaders' response to the OMI recommendation regarding consultation with VHA Clinical Risk Management on peer review and quality processes as the facility leaders' corrective actions were sufficient.

The OIG found a deficiency in the facility leaders' corrective action plan for the OMI recommendation regarding development of local procedures and guidelines to establish that a Peer Review Committee member with a level 3 should be reassessed by a neutral Peer Review Committee at another facility. Although quality management leaders developed a process for

external initial reviews of Peer Review Committee members, this corrective action does not ensure the integrity of a final level peer review designation as the Peer Review Committee, not a neutral reviewer, makes the final level determination.

The CMO and VCSC provided support to the general surgery department and COS as recommended by the OMI; however, the VISN academic affiliations officer was not aware of the OMI recommendation related to resident supervision, did not provide oversight to the facility's surgical residency program, and did not ensure compliance with VHA policy. The VCSC was responsive to requests from VISN leaders to conduct reviews of the former chief of surgery's clinical care, conduct on-site visits to the facility, and to have regular contact with the COS. However, the VISN surgical workgroup did not document vital information from the facility, which could have ramifications across other VISN facilities as well.

VISN executive leaders recognized the facility was vulnerable during times of leadership transition and was committed to supporting the facility through these transitions. VISN support should continue to ensure the sustainability of corrective actions and facilitate ongoing leadership transitions. Since July 2022, interim facility leaders had instituted several HRO initiatives aimed at improving communication, establishing governance policy, and increasing psychological safety. However, if previous leaders return, or temporary leaders have short assignment periods, the facility could lose any forward progress made toward HRO goals.

The VISN Director described previous facility leadership as having had "siloed communication routes" where "there was not a lot of cross communication across services." The VISN QMO indicated concerns that the previous Facility Director attempted to manage the OMI report recommendations with a small group of facility leaders, which limited transparency and the ability to discuss corrective actions. Those in leadership roles, such as the interim chief of surgery and the interim chief of quality, safety, and value, should have been provided the report and had knowledge of the report's findings and recommendations as both positions were responsible for corrective actions recommended in the report, and for coordinating responses. Interim facility leaders' have reduced communication silos with facility staff; however, the changes may not be sustainable due to the temporary nature of facility leader assignments.

While not a formal part of HRO, VHA mandated that facilities use standardized templates for local medical center policies and standardized operating procedures; respectively, these documents govern practice and responsibilities and detail steps and activities related to a process or procedure. VHA also mandates facilities use charters to outline responsibilities and functions of a standing group. Interim Facility Director 1 told the OIG of identifying concerns regarding the facility's lack of formalized governance processes upon arrival at the facility in July 2022.

While interim facility leaders demonstrated a commitment to HRO principles through development of a governance, leadership, and culture policy to support transparency, these changes were new at the time of inspection. Facility leaders should continue progress toward establishing governance and policy to support transparency and facilitate leadership transitions.

The progression of governance and policy management will challenge incoming interim leaders; therefore, sustainability, and continuation of the facility's HRO efforts require ongoing VISN oversight and support.

Interim facility leaders had made efforts to improve psychological safety at the facility. Facility and service leaders need to continue efforts to create a psychologically safe environment and VISN support and oversight will be necessary to sustain progress in the facility's unstable leadership environment.

The OIG evaluated VISN leaders' oversight in general and interviewed select VISN leaders and the VCSC to identify actions taken to ensure facility leaders had the tools and support necessary to implement sustainable solutions to the concerns identified by the OMI. Through site visits related to the OMI recommendations, VISN leaders identified further concerns. VISN leaders demonstrated commitment to enhanced oversight during current and upcoming facility leadership transitions. However, the recommendation to revoke privileges and subsequent report to external entities was delayed during a recent facility leadership transition in December 2022 and January 2023, suggesting opportunities for improvement in communication during periods of transition.

Recommendations 1–9

1. The VA Healthcare System Serving Ohio, Indiana and Michigan Network Director evaluates and ensures all Veterans Integrated Service Network 10 facilities comply with Veterans Health Administration requirements regarding resident supervision, specifically related to post-graduate year one on-site direct supervision.

2. The John D. Dingell VA Medical Center Director reviews the March 2023 National Surgery Office program review as referenced in the Office of the Medical Inspector report and ensures a comprehensive and sustainable response to the recommendations noted in the National Surgery Office memorandum.

3. The John D. Dingell VA Medical Center Director and facility leaders meet all Veterans Health Administration requirements for National Practitioner Data Bank and State Licensing Board reporting for healthcare providers that meet reporting criteria.

4. The John D. Dingell VA Medical Center Director ensures the chief of surgery facilitates and provides oversight of morbidity and mortality conferences.

5. The John D. Dingell VA Medical Center Director ensures that initial level 3 peer review results of Peer Review Committee members' cases are reassessed by another neutral VA facility Peer Review Committee for final level determination.

6. The VA Healthcare System Serving Ohio, Indiana and Michigan Network Director ensures the Veterans Integrated Service Network academic affiliations officer maintains awareness of and performs assigned roles and responsibilities per Veterans Health Administration requirements.

7. The VA Healthcare System Serving Ohio, Indiana and Michigan Network Director ensures the Veterans Integrated Service Network surgical workgroup reviews applicable Veterans Health Administration policies, and documents discussion and action plans to reflect facilities' compliance with Veterans Health Administration policy and surgical complexity level.

8. The VA Healthcare System Serving Ohio, Indiana and Michigan Network Director provides continued oversight and structured support to executive and service line leaders during key leader transitions, and monitors actions taken to ensure completion of action plans.

9. The John D. Dingell VA Medical Center Director reviews organizational communication channels and ensures consistency with Veterans Health Administration High Reliability Organization goals and considers the use of Veterans Health Administration resources such as the Veterans Health Administration National Center for Organization Development.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 31, 2023

From: Director, The VA Healthcare System Serving Ohio, Indiana and Michigan (10N10)

Subj: Healthcare Inspection—Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan

To: Director, Office of Healthcare Inspections (54HL07)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed the draft report of the Healthcare Inspection - Healthcare Inspection—Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan.

2. The VISN 10 VA Healthcare System is committed to ensuring Veterans we serve receive exceptional service at our medical centers. I concur with the responses and action plans submitted by VISN 10 and the John D. Dingell VA Medical. We will continue to partner with the Office of Inspector General and leadership at the John D. Dingell VA Medical Center to implement and sustain corrective actions.

3. If you have any questions or require further information, please contact the VISN 10 Quality Management Officer.

(*Original signed by:*)

Laura E. Ruzick, FACHE
Director, VISN 10 VA Healthcare System (10N10)

VISN Director Response

Recommendation 1

The VA Healthcare System Serving Ohio, Indiana and Michigan Network Director evaluates and ensures all Veterans Integrated Service Network 10 facilities comply with Veterans Health Administration directives regarding resident supervision, specifically related to post-graduate year one on-site direct supervision.

Concur.

Target date for completion: September 30, 2023

Director Comments

As described in this draft report, OIG found that post-graduate year one (PGY-1) general surgery residents on-call overnight lacked appropriate supervision as per requirements outlined in VHA Directive 1400.01. PGY-1 residents require on-site, direct supervision by either a supervising practitioner or a more advanced resident. In response to these findings, by January 2023, the facility successfully implemented a revised staffing model that was compliant with direct supervision requirements. Compliance for all general surgery programs within VISN 10 was then verified by the VISN 10 Chief Surgical Consultant (VCSC). In February 2023, the Annual Compliance and Oversight Report (ACOR) was completed, submitted and attested to by 100% of the VISN 10 facility Designated Education Officers. The VISN 10 Chief Medical Officer (CMO) reviewed the ACORs with the Network Academic Affiliations Officer on February 3, 2023, with no concerning findings related to supervision.

VISN leadership has determined that additional action is needed to verify compliance related to PGY-1 on-site supervision across all trainee specialties, including medicine, surgery and psychiatry. As such, the Network Academic Affiliations Officer will oversee development and completion of a supervision monitoring tool by all facilities through the VISN 10 Academic Affiliations Subcommittee. The tool will assess adherence to key components of Health Professions Trainee (HPT) supervision requirements, with emphasis on monitoring PGY-1 supervision requirements; reviewing Patient Safety, Risk Management, and Quality Improvement Data and documentation of resident supervision for all VISN 10 facilities. The process will include a request for supporting documentation as evidence of adherence to the core tenants of supervision (e.g., call schedules, Educational Activity Record). Progress will be reported to the VISN 10 Healthcare Delivery Committee with request for closure when compliance is verified for 100% of all VISN 10 facilities.

Recommendation 6

The VA Healthcare System Serving Ohio, Indiana and Michigan Network Director ensures the Veterans Integrated Service Network academic affiliations officer maintains awareness of and performs assigned roles and responsibilities per Veterans Health Administration requirements.

Concur.

Target date for completion: October 31, 2023

Director Comments

The VISN 10 CMO Office has and continues to suspense and track all oversight actions issued from the Office of Academic Affiliations (OAA) to ensure oversight of facility compliance with VHA requirements. Examples include ReDPro checklist results, Annual Report of Health Services Training and Medical and Dental Resident Verification Allocation Process. In addition, OAA has begun issuing random audits for ReDPro disbursements and executed affiliation agreements, which the VISN CMO Office will continue to oversee. To ensure the Network Academic Affiliations Officer maintains awareness of and performs assigned roles and responsibilities per VHA requirements, VISN leadership has determined that the following actions will be implemented:

- The CMO will meet monthly with the Network Academic Affiliations Officer and will inform the Network Academic Affiliations Officer of all investigations, inquiries and/or findings involving HPTs at any VISN 10 facility.
- Reporting from the VISN 10 Academic Affiliations Subcommittee to the VISN 10 Healthcare Delivery Committee will increase from bi-annually to quarterly in FY 24 beginning with the FY 23 annual report due October 2023.

Progress will be reported to the VISN 10 Healthcare Delivery Committee with request for closure when minutes demonstrate that the roles and responsibilities of the Network Academic Affiliations Officer have been executed in alignment with VHA requirements for two consecutive quarters.

Recommendation 7

The VA Healthcare System Serving Ohio, Indiana and Michigan Network Director ensures the VISN surgical workgroup reviews applicable Veterans Health Administration policies, and documents discussion and action plans to reflect facilities' compliance with Veterans Health Administration policy and surgical complexity level.

Concur.

Target date for completion: January 31, 2024

Director Comments

The VISN 10 VCSC ensures the VISN surgical workgroup reviews applicable VHA policies, and documents discussion and action plans to reflect facilities' compliance with VHA policy and surgical complexity level. Effective July 2022, review of National Surgery Office or surgery-related policies was added as a standing agenda item to VISN 10 surgical workgroup meetings. In September 2022, surgical management from 100% of VISN 10 facilities completed a self-assessment checklist to attest areas of compliance/non-compliance with VHA Directive 1220.

Effective July 2023, facilities will now complete a monthly Invasive Complexity attestation through the VISN surgical workgroup. Minutes will include documentation of any waivers. Attestations will be validated during annual Surgery Integrated Clinical Community site visits. VISN surgical workgroup meeting minutes will also include discussion of all suspense-related items, clinical restructuring requests, and key quality and patient safety indicators consistent with VHA requirements. Progress will be reported to the VISN 10 Healthcare Delivery Committee with request for closure when VISN surgical workgroup minutes demonstrate review of VHA policies and evidence of discussion and action plans to reflect facilities' compliance with VHA policy and surgical complexity level for six consecutive months.

Recommendation 8

The VA Healthcare System Serving Ohio, Indiana and Michigan Network Director provides continued oversight and structured support to executive and service line leaders during key leader transitions, and monitors actions taken to ensure completion of action plans.

Concur.

Target date for completion: September 30, 2023

Director Comments

VISN executive leaders have actively engaged and supported facility leaders during their period of leadership transition and closely monitored the completion of action plans developed as a result of internal and external reviews. Specifically, the VISN 10 Network Director established twice weekly meetings with the facility and VISN Executive Leadership Teams (ELTs), including Quality and Patient Safety, starting July 9, 2022. The purpose of these meetings is to monitor progress on findings from VISN and national program reviews, provide support in the form of both human and financial resources and to coach the facility on standard practices, communication strategies and HRO principles. Additionally, expectations were set, leadership focus was prioritized and sustainment of corrective actions was addressed. The list of action items expanded as program reviews were completed and as repeat reviews were conducted by select programs, starting in September 2022, including Quality and Patient Safety and Nursing.

The cadence of the twice weekly meetings changed to weekly meetings in December 2022, and to monthly meetings in April 2023.

Following the development and implementation of a facility governance plan and policy in December 2022, VISN leadership began transitioning the process for monitoring sustainment of corrective actions to the facility. Training was provided to key facility stakeholders and over the next several months, actions requiring sustainment monitoring were formally delegated to the appropriate board or committee for monitoring on their respective action trackers. All chartered committees are aligned with the Executive Leadership Board per the facility's new governance policy. This supports a robust reporting structure with increased transparency of isolated and cross cutting issues.

The Network Director made quarterly, in-person site visits holding Town Halls, rounding in the facility and meeting with leaders in July 2022, October 2022 and January 2023, and will continue biannually going forward. In addition, the VISN Quality and Patient Safety team will continue quarterly site reviews for the remainder of FY23, focusing on different areas on each visit as well as reviewing areas of continued concern. Other VISN program leads continue their annual reviews, noting both new and repeat findings as well as successes in reports to facility leaders. Additional site visits will occur as issues arise and/or if additional support is needed. Recommendations from those visits are placed on the facility's respective action trackers for follow-up to resolution by the responsible boards or committees. On June 1, 2023, a meeting was held between the VISN ELT and John D. Dingell VAMC leadership to set expectations for future oversight communication and support until permanent leadership is in place.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 31, 2023

From: Director, John D. Dingell VA Medical Center (553)

Subj: Healthcare Inspection—Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report at the John D. Dingell VA Medical Center in Detroit, Michigan

To: Director, The VA Healthcare System Serving Ohio, Indiana and Michigan (10N10)

1. I reviewed the draft report, Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report at the John D. Dingell VA Medical Center in Detroit, Michigan and concur with the action plan as submitted.
2. We are committed to providing safe, timely, and highest quality care to the Veterans we serve. We will continue our efforts to become a High Reliability Organization, and to implement and sustain the improvements detailed in the attached action plan.
3. If you have any additional questions, please contact the Chief of Quality and Patient Safety (QPS).

(*Original signed by*:)

Chris Cauley, FACHE
Interim Executive Director

Facility Director Response

Recommendation 2

The John D. Dingell VA Medical Center Director reviews the March 2023 National Surgery Office program review as referenced in the Office of the Medical Inspector report and ensures a comprehensive and sustainable response to the recommendations noted in the National Surgery Office memorandum.

Concur.

Target date for completion: January 31, 2024

Director Comments

The National Surgery Office Consultative Review report was received on March 20, 2023. The report was reviewed by the leadership team and a comprehensive action plan was developed for all recommendations. The Acting Chief of Staff is point of contact for action completion. Six of the ten recommendations have been completed. Action plan progress, completion, and sustainment is tracked and monitored in the Healthcare Delivery Board, which is chaired by the Acting Chief of Staff. Closure will be requested upon completion of the remaining action items with evidence of compliance for six consecutive months.

Recommendation 3

The John D. Dingell VA Medical Center Director and facility leaders meet all Veterans Health Administration requirements for National Practitioner Data Bank and State Licensing Board reporting for healthcare providers that meet reporting criteria.

Concur.

Target date for completion: January 31, 2024

Director Comments

Training on reporting requirements and processes was provided by the Office of General Counsel for VISN 10 service chiefs in April 2023. Additionally, VISN leadership has created an SLB reporting process checklist and flowchart that will be shared with facilities after final VISN review and approval.

The facility credentialing and privileging manager will continue to utilize the NPDB and SLB tracker, as well as the VISN checklist, to monitor turnaround times for each of the five steps of reporting, as well as overall reporting turnaround time. Compliance and sustainment will be monitored monthly in the Clinical Executive Committee, which reports to the Healthcare Delivery Board quarterly. Sustainment will be documented in committee minutes. Closure will

be requested when reporting for NPDB and SLB meets >90% VHA requirements for six consecutive months.

Recommendation 4

The John D. Dingell VA Medical Center Director ensures the chief of surgery facilitates and provides oversight of morbidity and mortality conferences.

Concur.

Target date for completion: June 30, 2023

Director Comments

The permanent Chief of Surgery began employment at the facility on January 1, 2023. The Chief of Surgery has facilitated all M&M conferences since beginning employment and will continue to do so indefinitely. Facility leadership has also issued a memorandum delegating responsibility of facilitating M&M conferences to the Chief of Surgery. Evidence of compliance will be M&M conference minutes demonstrating the Chief of Surgery's attendance and facilitation of M&M conferences, which is tracked and monitored through the Healthcare Delivery Board. The facility anticipates closure in June 2023, as this action has been successfully implemented since January 2023.

Recommendation 5

The John D. Dingell VA Medical Center Director ensures that initial level 3 peer review results of Peer Review Committee members' cases are reassessed by another neutral VA facility Peer Review Committee for final level determination.

Concur.

Target date for completion: January 31, 2024

Director Comments

In June 2022, the facility Peer Review Committee developed and implemented a new process for all initial reviews of Peer Review Committee members to be sent for external review, as documented in a facility Job Instruction Sheet (JIS). This JIS will be converted to a formal Standard Operating Procedure (SOP) that includes a step in the process for initial level 3 peer review results of Peer Review Committee members' cases to be reassessed by another neutral VA facility Peer Review Committee for final level determination. As such, the facility has established a memorandum of understanding with a nearby VA facility to review level 3 cases of peer review committee members. If the nearby VA facility does not have the respective specialty associated with the peer review case, the VISN 10 Risk Management Officer will assist to coordinate at an appropriate external facility.

The SOP will be reviewed and approved by the Peer Review Committee and Healthcare Delivery Board, which provides governing oversight of the Peer Review Committee. SOP compliance will be monitored through Peer Review Committee minutes by the Healthcare Delivery Board. Closure will be requested after two consecutive quarters of demonstrated compliance.

Recommendation 9

The John D. Dingell VA Medical Center Director reviews organizational communication channels and ensures consistency with Veterans Health Administration High Reliability Organization goals and considers the use of Veterans Health Administration resources such as the Veterans Health Administration National Center for Organization Development.

Concur.

Target date for completion: October 31, 2023

Director Comments

The facility has had an assigned High Reliability Organization (HRO) Leader Coach since October 2021 and a dedicated HRO Coordinator since September 2022. Since October 2022, efforts to promote transparency, psychological safety and communication throughout the facility that have been implemented, including daily all-employee morning reports (featuring a weekly local HRO story), a weekly email from the director featuring HRO messaging, monthly all-employee town halls featuring an HRO update, HRO leadership rounding and multiple applications that allow employees to anonymously ask questions or provide suggestions directly to the executive leadership team. Additionally, facility leadership has initiated the implementation of a huddle approach within the all-employee morning report to promote consistent, bi-directional communication. The facility's progress as an HRO is discussed regularly by executive leadership and monthly in the Quality and Patient Safety Board.

The facility will request consultation from the National Center for Organizational Development (NCOD) to evaluate available services that could be beneficial to the facility. The facility has taken advantage of NCOD services in the past and is currently a VA Voices site. Closure will be requested upon completion of NCOD consultation.

OIG Contact and Staff Acknowledgments

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