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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 22: VA Desert Pacific Healthcare Network in Long Beach, California

CHIP Report | 22-00057-54 | January 23, 2024

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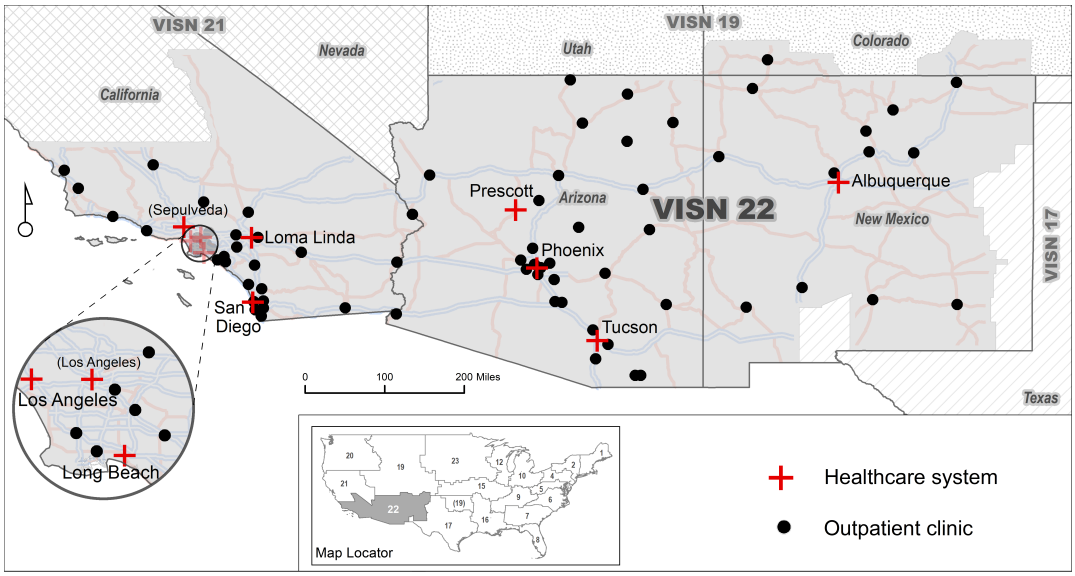

Figure 1. *Veterans Integrated Service Network 22: VA Desert Pacific Healthcare Network. Source: Veterans Health Administration Site Tracking Database (accessed March 16, 2022).*

Abbreviations

AES	All Employee Survey
CHIP	Comprehensive Healthcare Inspection Program
CMO	chief medical officer
ELT	executive leadership team
FY	fiscal year
HCS	health care system or healthcare system
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Patient Aligned Care Team
QMO	quality management officer
SDOH	social determinants of health
SHEP	Survey of Healthcare Experiences of Patients
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This VA Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program report provides a focused evaluation of leadership performance and oversight by Veterans Integrated Service Network (VISN) 22: VA Desert Pacific Healthcare Network in Long Beach, California.[1] The inspection covers key clinical and administrative processes that are associated with promoting quality care.

While facilities are located within the same VISN, each facility encounters unique challenges given their locale and veteran population.[2] In order to highlight diverse circumstances, the OIG reviewed the New Mexico VA Health Care System (HCS) in Albuquerque (Albuquerque) and the VA Greater Los Angeles HCS in California (Greater LA).[3] The assessment focused on how the integration of high reliability organization concepts, coupled with unique facility elements and social determinants of health, affected patient care.[4] Challenges and successes at Albuquerque and Greater LA, along with opportunities for VISN 22 to support these facilities, are highlighted throughout the report.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each VISN approximately once every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff credentialing and privileging
4. Environment of care
5. Mental health (focusing on suicide prevention)

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

[2] Each VISN is "a shared system of care working together to better meet local health care needs and provide Veterans greater access to care." VA, *2020 Functional Organization Manual version 6,* September 1, 2021.

[3] "VA Desert Pacific Healthcare Network (VISN 22)," VA, accessed December 22, 2022, https://www.desertpacific.va.gov/DESERTPACIFIC/about/index.asp.

[4] "Social determinants of health are nonmedical factors that influence health outcomes." "Social Determinants of Health at CDC," Centers for Disease Control and Prevention, accessed February 27, 2023, https://www.cdc.gov/about/sdoh/index.html.

The OIG conducted an unannounced inspection of the VA Desert Pacific Healthcare Network during the week of March 21, 2022. The OIG also inspected the following VISN 22 facilities during the weeks of February 14 and 28 and March 7, 14, and 21, 2022:

- New Mexico VA HCS (Albuquerque)
- Northern Arizona VA HCS (Prescott)
- Phoenix VA HCS (Arizona)
- Southern Arizona VA HCS (Tucson)
- VA Greater Los Angeles HCS (California)
- VA Loma Linda HCS (California)
- VA Long Beach HCS (California)
- VA San Diego HCS (California)

The OIG conducted additional site visits to Albuquerque and Greater LA in August and September 2022.

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. The findings presented in this report are a snapshot of VISN 22 and facility performance within the identified focus areas at the time of the OIG inspection. The findings may help VISN leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement and issued two recommendations to the Network Director and Chief Medical Officer in the following areas of review: Quality, Safety, and Value and Medical Staff Credentialing and Privileging. These results are detailed throughout the report and summarized in appendix A on page 25.

The number of recommendations should not be used as a gauge for the overall quality of care provided within this VISN. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address issues that may eventually interfere with the delivery of quality health care.

In addition, while Albuquerque and Greater LA may vary in patient population, geographic location, and available services, the OIG identified similar barriers to patient care, albeit with different causes. The OIG believes that stable leadership and succession planning, along with

ensuring a culture of safety, would facilitate VISN 22 facilities to achieve the goal of providing high-quality care to unique veteran populations.

VA Comments

The interim Veterans Integrated Service Network Director concurred with the report (see appendix D, page 31, for the full text of the directors' comments). The OIG considers recommendations 1 and 2 closed.[5]

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

[5] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and, therefore, closed both recommendations as implemented before publication of the report.

Contents

Purpose

This VA Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report presents inspection results from an evaluation of the VA Desert Pacific Healthcare Network (Veterans Integrated Service Network [VISN 22]) leadership performance and oversight, which includes an examination of a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. Additionally, this report presents findings from an in-depth review of two VISN 22 facilities: the New Mexico VA Health Care System (HCS) in Albuquerque (Albuquerque), and the VA Greater Los Angeles HCS in Los Angeles, California (Greater LA).[1] Although these facilities are a part of the same VISN, as described through this report in "spotlight" boxes, each facility encounters unique challenges given its locale and veteran population.[2] The OIG reports findings to VISN leaders so they can make informed decisions to improve care.

Background

VISN 22

The VISN is defined based on "VHA's [Veterans Health Administration's] natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VA medical centers (VAMC), clinics and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the Veterans health care system."[3]

The VA Desert Pacific Healthcare Network, VISN 22, is one of 18 healthcare networks operated nationwide by VHA. VISN 22 is comprised of 8 facilities and 65 community-based outpatient clinics.[4] According to data from the VA National Center for Veterans Analysis and Statistics, VISN 22 had a veteran population of 1,587,832 at the beginning of fiscal year (FY) 2022 and a projected FY 2023 population of 1,552,583. The VISN provided care for 523,028 unique patients

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

[2] "VA Desert Pacific Healthcare Network (VISN 22)," VA, accessed February 2, 2023, https://www.desertpacific.va.gov/DESERTPACIFIC/about/index.asp; Each VISN is "a shared system of care working together to better meet local health care needs and provide Veterans greater access to care." VA, *2021 Functional Organization Manual Version 7*, September 30, 2021.

[3] *Hearing on the Curious Case of the VISN Takeover: Assessing VA's Governance Structure, Before the House Committee on Veterans' Affairs*, 115th Cong. (May 22, 2018) (statement of Carolyn Clancy, MD, Executive in Charge, VHA).

[4] "VA Desert Pacific Healthcare Network (VISN 22)," VA.

in FY 2019; 521,747 in FY 2020; and 553,231 in FY 2021. The medical care budget was $5,420,060,167 for FY 2019; $6,654,281,199 for FY 2020; and $7,152,105,350 for FY 2021. This represents a two-year increase of approximately 32 percent. At the time of the OIG visit, the VA Desert Pacific Healthcare Network consisted of facilities and community-based outpatient clinics serving more than 1.5 million veterans residing in Arizona, Colorado, New Mexico, and Southern California.

Albuquerque and Greater LA

Although Albuquerque and Greater LA are similar in that they are within the same VISN and take local social determinants of health (SDOH) into consideration when caring for veterans, the facilities differ in many areas.[6] Albuquerque is in New Mexico, with a Hispanic population of almost 50 percent. Its Native American population is almost five percent.[7] Homelessness, addiction, poverty, and the rurality of the state are factors identified by Albuquerque staff and leadership as cultural challenges.

According to the Greater LA Facility Director, about 10,000 veterans who are or were formerly homeless are provided health care in the Greater LA continuum of care. This aspect of care is unique and drives additional engagement visits from external assistance and oversight groups.[5]

Greater LA is located in one of the most expensive cities in the United States. According to facility human resource staff and the acting nurse recruiter, the high cost of living affects the recruitment and retention of staff. They further stated that staff often engage in long commutes to the facility in order to live in more affordable neighborhoods.

Social Determinants of Health

SDOH such as locality, patient demographics, and human and equipment resources available within and outside a facility may challenge facility leaders to develop ways to organize services

[5] Information provided by the Greater LA Facility Director during the OIG CHIP review, Triennial Joint Commission visit, Joint Commission Laboratory visit, and House and Senate Veterans Affairs Committee congressional staffer oversight visits.

[6] VHA facilities are classified as levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. A level 1a facility has "high volume, high risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency, and Staffing (OPES), "Facility Complexity Level Model Fact Sheet," January 28, 2021, Albuquerque is designated as complexity level 1b and is the only VHA facility in the state. The primary facility is located in Albuquerque and has 13 community-based outpatient clinics, some located in remote areas of New Mexico and western Colorado. Greater LA is designated as a 1a complexity facility.

[7] "QuickFacts, Albuquerque city, New Mexico; New Mexico," The United States Census Bureau, accessed on October 2, 2023, https://www.census.gov/quickfacts/fact/table/albuquerquecitynewmexico,NM/PST045222.

differently to deliver health care uniformly to enrolled patients. According to the US Department of Health and Human Services,

> SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. . . Examples of SDOH include
>
> - safe housing, transportation, and neighborhoods;
> - racism, discrimination, and violence;
> - education, job opportunities, and income;
> - access to nutritious foods and physical activity opportunities;
> - polluted air and water; and
> - language and literacy skills.
>
> SDOH also contribute to wide health disparities and inequities.[8]

The OIG's review of Albuquerque and Greater LA identified several SDOH that affect the availability of VHA services. See appendix C for additional details regarding SDOH unique to each facility.

VHA's Journey to Become a High Reliability Organization

In 2019, VHA committed to creating an enterprise-wide high reliability organization (HRO) with the intention of delivering care through high reliability principles. HROs have been shown to "experience fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments."[9] HRO implementation includes three pillars, five principles, and seven values that make up the "framework and activities used to implement common practices across VHA."[10] Leadership commitment, a culture of safety, and continuous process improvement with the goal of zero harm make up the three pillars and are interwoven and constant throughout all levels of the organization.

[8] "Social Determinants of Health," US Department of Health and Human Services, accessed February 21, 2023, https://health.gov/healthypeople/priority-areas/social-determinants-health.

[9] VHA, *VHA High Reliability Organization (HRO) Reference Guide*, March 31, 2021.

[10] VHA, *HRO Placement*, September 2021; VHA, *VHA High Reliability Organization (HRO) Reference Guide*; VHA's five HRO principles are: (1) sensitivity to operations, (2) preoccupation with failure, (3) reluctance to simplify, (4) commitment to resilience, and (5) deference to expertise. HRO values are it's all 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 communication.

Figure 2. *Foundational HRO practices, principles, and values.*
Source: VHA, HRO Placemat, September 2021.

Methodology

The inspection team examined VISN 22 operations from October 21, 2016, through September 16, 2022. An unannounced multiday inspection was conducted during the week of March 21, 2022.[11] During the visit, the OIG did not receive complaints beyond the scope of this inspection that required referral to the OIG hotline. The OIG also inspected the following VISN 22 facilities beginning the weeks of February 14 and 28; and March 7, 14, and 21, 2022:

- New Mexico VA HCS (Albuquerque)[12]
- Northern Arizona VA HCS (Prescott)[13]
- Phoenix VA HCS (Arizona)[14]
- Southern Arizona VA HCS (Tucson)[15]
- VA Greater Los Angeles HCS (California)[16]
- VA Loma Linda HCS (California)[17]
- VA Long Beach HCS (California)[18]
- VA San Diego HCS (California)[19]

The OIG conducted additional site visits to Albuquerque and Greater LA in August and September 2022. The OIG team reviewed documents, VHA Strategic Analytics for Improvement and Learning reports, and internal OIG data.[20] The OIG provided Albuquerque and Greater LA executive leaders with a list of questions related to the performance metrics at each respective

[11] The range represents the time from the previous Clinical Assessment Program review of the Southern Arizona VA HCS to the completion of the unannounced week-long virtual CHIP visit on March 25, 2022.

[12] New Mexico VA HCS's primary facility is the Raymond G. Murphy VA Medical Center (VAMC) (Albuquerque).

[13] Northern Arizona VA HCS's primary facility is the Bob Stump VAMC (Prescott).

[14] Phoenix VA HCS's primary facility is the Carl T. Hayden VAMC (Arizona).

[15] Southern Arizona VA HCS's primary facility is the Tucson VAMC.

[16] VA Greater Los Angeles HCS's primary facility is the West Los Angeles VAMC (California).

[17] VA Loma Linda HCS's primary facility is the Jerry L. Pettis Memorial Veterans' Hospital (California).

[18] VA Long Beach HCS's primary facility is the Tibor Rubin VAMC (California).

[19] VA San Diego HCS's primary facility is the Jennifer Moreno VAMC (California).

[20] "Strategic Analytics for Improvement and Learning Value Model or SIAL, is a system for summarizing hospital system performance within Veterans Health Administration (VHA). SAIL assesses 25 quality measures in areas such as death rate, complications, and patient satisfaction, as well as overall efficiency and physician capacity at individual VA Medical Centers (VAMCs)." Department of Veterans Affairs, *Strategic Analytics for Improvement and Learning (SAIL)-Quality of Care*, September 11, 2017. Because SAIL references performance measure data by fiscal year and quarter, the review period covered select operations from October 1, 2018 (Q1 FY 2019), through September 30, 2021 (Q4 FY2021).

facility, and the potential impact on specific aspects of clinical care delivery in the system's inpatient and outpatient settings. The OIG team also interviewed key managers and staff.

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations throughout VISN 22:[21]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff credentialing and privileging
4. Environment of care
5. Mental health (focusing on suicide prevention)

To highlight the diverse circumstances of VISN 22 facilities, the OIG reviewed Albuquerque and Greater LA. The assessment of these facilities was done with a focus on how the integration of HRO concepts, coupled with unique facility challenges, affected patient care delivery. Challenges and successes at Albuquerque and Greater LA, along with opportunities for VISN 22 to support these facilities, can be found in the "spotlight" boxes throughout the report.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[22] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VISN leaders complete corrective actions.

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

[21] CHIP site visits addressed these processes during fiscal year (FY) 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

[22] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[23] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[24]

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[25] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their vision and strategy, and "practice systems thinking and collaboration across boundaries."[26] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[27]

To assess this VISN's risks, the OIG considered the following indicators:

1. Executive leadership position stability
2. Employee satisfaction
3. Patient experience
4. Access to care

Executive Leadership Position Stability

At the time of the OIG visit, VISN 22 had a leadership team consisting of the Network Director, interim Deputy Network Director, Chief Medical Officer (CMO), Chief Financial Officer, interim Quality Management Officer (QMO), and Organizational Excellence Director. These executive leaders had been working together for two weeks. The VISN leadership team had experienced some instability, with the QMO and the newly created chief nursing officer positions vacant. Also, the deputy network director position had been vacant since June 2021,

[23] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

[24] Danae F. Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[25] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[26] Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[27] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement, White Paper, 2017.

with four different interim staff filling in. The Network Director had been on board since October 2018, and the CMO since February 2021. The Chief Financial Officer was the longest tenured member of the leadership team, having arrived in December 2008. The Organizational Excellence Director was added to the VISN executive team in May 2021.

Between 2019 and 2022, both Albuquerque and Greater LA experienced turnover in their executive leadership teams (ELTs) and had employees in acting positions for sustained periods of time. This instability may have slowed actions or innovations that might have otherwise grown under permanent team members working toward a collective goal.

Leadership instability also affected Albuquerque and Greater LA.

While reviewing the various aspects of leadership at Albuquerque and Greater LA, the OIG identified two opportunities for VISN 22 to support the facilities in their efforts, including (1) providing support to both Albuquerque and Greater LA's ELTs to promote stability and decrease turnover, and (2) collaborating with facilities to establish and routinely report on leadership development and succession planning activities.

Employee Satisfaction

The All Employee Survey (AES) is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[28] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on VISN leaders. According to the VHA National Center for Organizational Development, AES scores of 3.50 and above represent a strength and scores below 3.50 indicate action plans should be developed.[29]

The OIG reviewed VA's AES results from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal (see figure 3).[30]

[28] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center. (This website is not publicly accessible.)

[29] VHA National Center for Organizational Development, "VA All Employee Survey (AES) Frequently Asked questions (FAQs)," August 25, 2020. (This website is not publicly accessible.)

[30] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders' AES scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

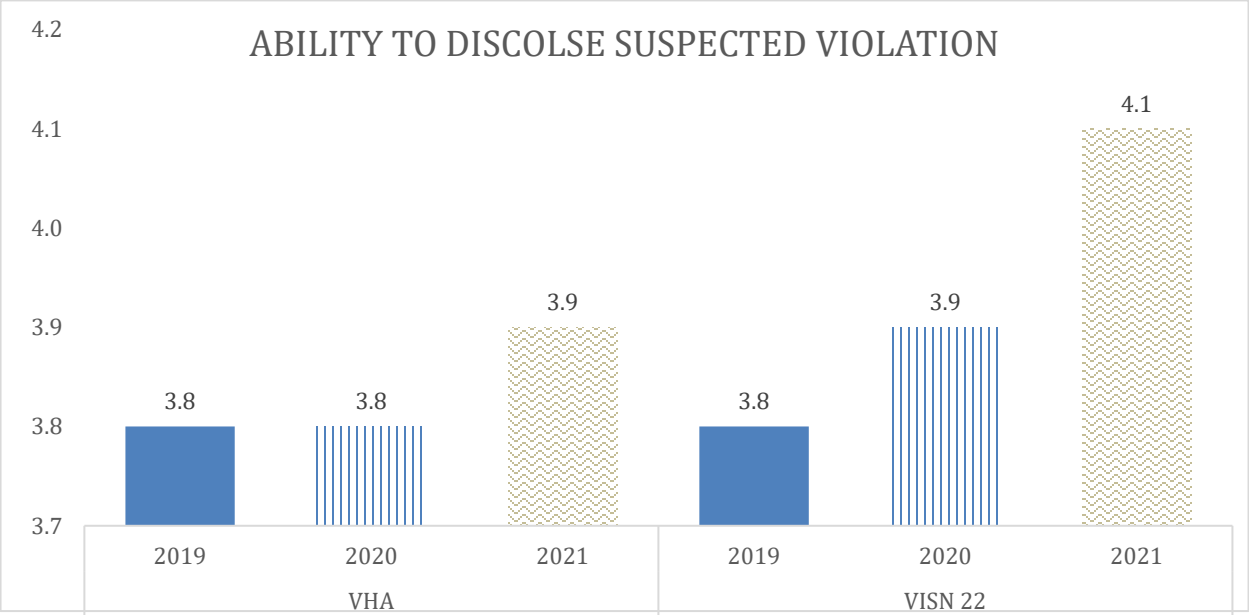

Figure 3. *AES results for the question "I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal."*

Source: VA AES (accessed February 16, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

For FY 2022, the OIG found that Albuquerque reported an overall AES score of 3.94. Leaders at Greater LA stated that the overall AES score was 3.80. Some examples of staff responses to the OIG included multiple staff reporting feeling psychologically unsafe and suffering from burnout.

Patient Experience

VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients (SHEP) program.[31]

VHA also collects SHEP data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[32] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the VISN from FY 2018 through FY 2021. Figures 4–6 provide relevant survey results for VHA and VISN 22.[33]

[31] "Patient Experiences Survey Results," VHA Support Service Center. (This website is not publicly accessible.)

[32] "Patient Experiences Survey Results," VHA Support Service Center. (This website is not publicly accessible.)

[33] Scores are based on responses by patients who received care within the VISN.

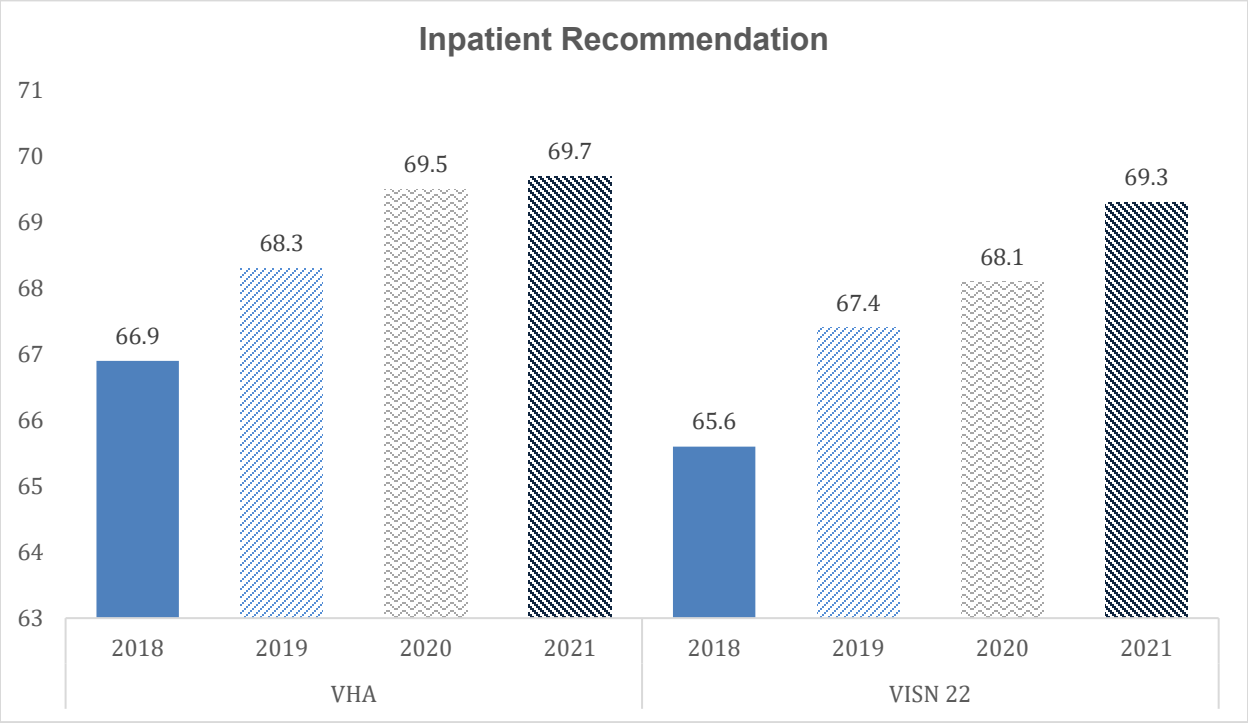

Figure 4. *SHEP results for the question "Would you recommend this hospital to your friends and family?"*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The response average is the percent of "Definitely yes" responses.

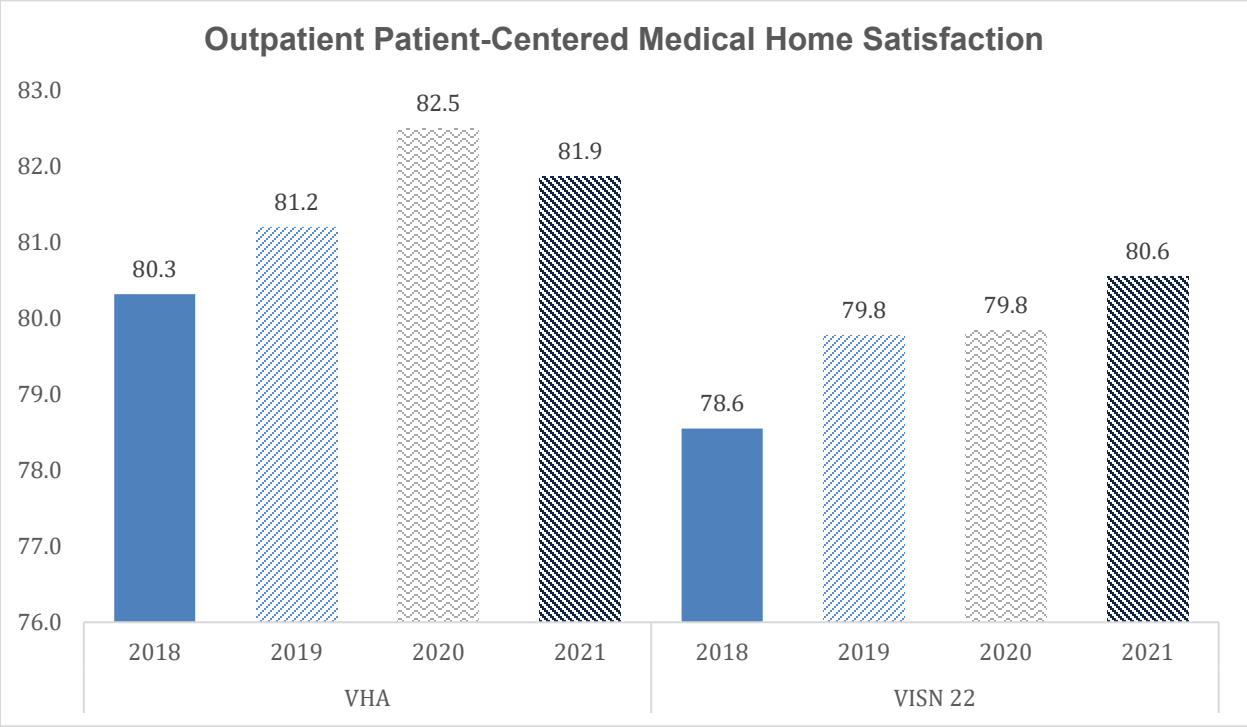

Figure 5. *SHEP results for the question: "Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?"*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The response average is the percent of "Very satisfied" and "Satisfied" responses.

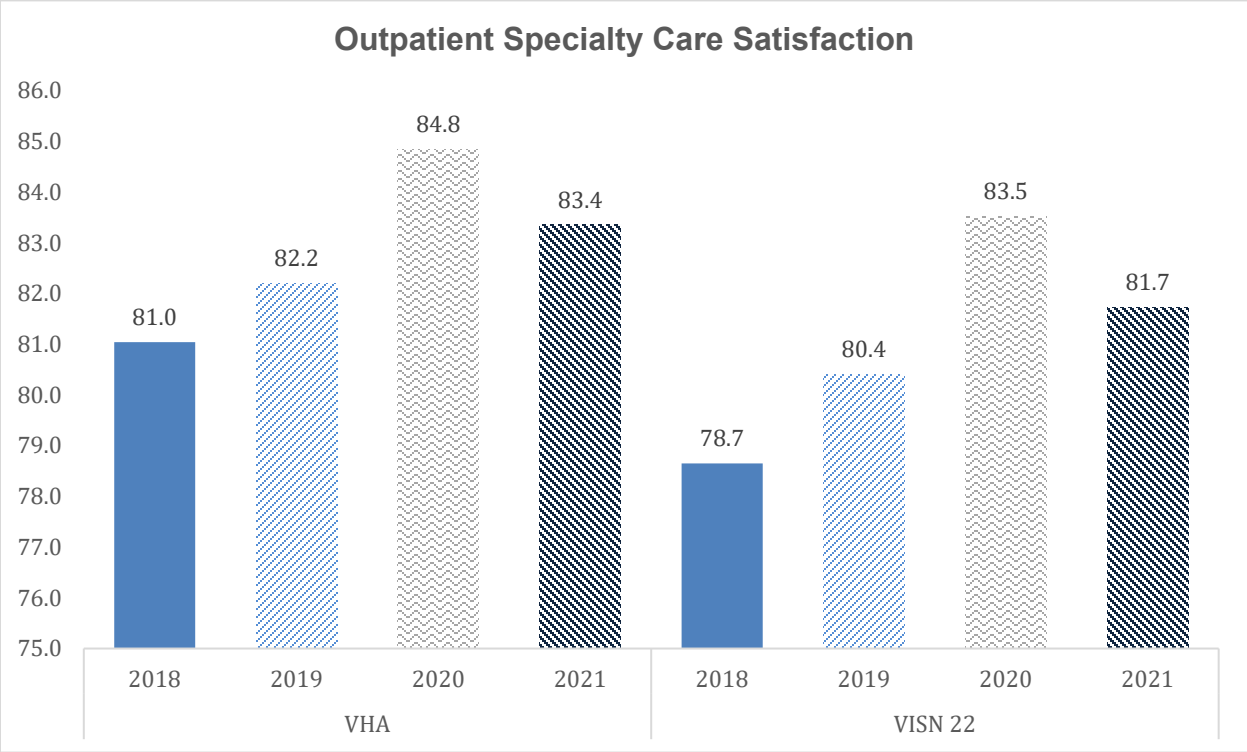

Figure 6. *SHEP results for the question: "Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?"*

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The response average is the percent of "Very satisfied" and "Satisfied" responses.

Access to Care

A VA priority is ensuring timely access to the best care and benefits for the nation's veterans. VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates. VHA's goal is to provide patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[34]

To examine access to primary and mental health care within VISN 22, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary care and mental

[34] The "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request. . . The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity." VHA Directive 1230(5), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended September 24, 2021. (VHA rescinded and replaced this directive with VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022).

health clinics for the most recently completed quarter. Tables 1 and 2 provide wait time statistics for completed primary care and mental health appointments from October 1 through December 31, 2021.[35]

Table 1. Primary Care Appointment Wait Times (October 1 through December 31, 2021)

Facility	New Patient Appointments	Average New Patient Wait Times from Create Date (Days)
VISN 22	9,503	23.5
New Mexico VA HCS (Albuquerque)	372	29.5
Northern Arizona VA HCS (Prescott)	506	26.7
Phoenix VA HCS (Arizona)	1,316	32.1
Southern Arizona VA HCS (Tucson)	1,710	16.2
VA Greater Los Angeles HCS (California)	1,502	17.4
VA Loma Linda HCS (California)	513	33.5
VA Long Beach HCS (California)	1,699	17.4
VA San Diego HCS (California)	1,885	23.1

Source: VA Corporate Data Warehouse (accessed February 17, 2022).

Note: The OIG did not assess VA's data for accuracy or completeness.

[35] Primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine. Mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual.

Table 2. Mental Health Appointment Wait Times (October 1 through December 31, 2021)

Facility	New Patient Appointments	Average New Patient Wait Times from Create Date (Days)
VISN 22	2,134	20.0
New Mexico VA HCS (Albuquerque)	75	37.8
Northern Arizona VA HCS (Prescott)	54	11.5
Phoenix VA HCS (Arizona)	562	19.7
Southern Arizona VA HCS (Tucson)	142	12.3
VA Greater Los Angeles HCS (California)	145	26.8
VA Loma Linda HCS (California)	25	40.2
VA Long Beach HCS (California)	716	14.9
VA San Diego HCS (California)	415	20.3

Source: VA Corporate Data Warehouse (accessed February 17, 2022).

Note: The OIG did not assess VA's data for accuracy or completeness.

VISN wait times are monitored through the Primary Care and Mental Health Integrated Clinical Community and Healthcare Delivery Councils. To improve access, leaders explained that the VISN operated telehealth hubs for staff to provide primary and mental healthcare coverage for its facilities. The primary care hub had 42 full-time equivalent employees, and from October 2021 through February 2022, staff completed more than 8,000 patient encounters. The mental healthcare hub had 48 full-time equivalent employees, and in February 2022, staff completed 1,855 patient encounters.

VHA's Patient Aligned Care Team (PACT) serves as the patient's primary access to VHA's facilities. In the PACT model, a patient is assigned to a core care team, referred to as a teamlet. VHA uses PACT not only to ensure continuity of care, but to also establish longitudinal relationships with the patient. Access to the PACT is an essential element to the delivery of quality care.

In FY 2019 through 2022, primary care services under the VHA PACT model were delivered to 56,532 and 96,635 patients at Albuquerque and Greater LA, respectively.

Albuquerque has approximately 20 PACT teamlets located at the facility, and an additional 29 among the 13 community-based outpatient clinics (CBOCs). Facility leaders told the OIG that recruitment of PACT providers and other PACT staff is a challenge for the facility due to location and salary. One approach used by the facility to recruit providers is by hiring through the US Public Health Service.

Albuquerque depends on specialty services in the community. The farthest CBOC is about 196 miles from the main facility. Community care is utilized by CBOCs due to patients' travel burden to get to the facility. However, due to the ruralness of these clinics, the supply of specialty care may be limited or not available when community care is needed. The top five specialties sent from the facility in FY 2022 were imaging/radiology, optometry, dental, home health, and surgery.

Greater LA has approximately 19 PACT teamlets located at the facility and an additional 62 among their CBOCs. The OIG was told in an interview with the chief of Primary Care that Greater LA's academic affiliations with resident training provide an advantage as it presents the potential for recruiting graduates who train through the facility and may want to join the facility after their residency.[36] The farthest CBOCs under Greater LA are approximately 150 miles from the main facility. The top five community care consults for specialties sent from the facility in FY 2022 were imaging/radiology, rehabilitation, mental health, surgery, and home health.

The OIG recognizes opportunities exist for VISN 22 to support Albuquerque in the facility's efforts to provide access to care for all veterans. These include, (1) providing support to Albuquerque in meeting its goals to address the lack of veteran health care in rural areas, and to ensure VHA services and resources are provided to indigenous veterans when and where they are needed; and (2) providing support to Albuquerque to address veteran access to specialty care in the community by establishing collaborative relationships with specialty care providers and evaluating VISN 22's network of hospitals for interfacility support for the delivery of specialty care.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[36] Greater LA is affiliated with the University of California, Los Angeles, and the University of Southern California; as well as over 45 other colleges, universities, and vocational schools. The OIG was told in an interview with the chief of Primary Care that medical residents are integrated into the facility's PACT model and follow patients during their training. Some of the facility's PACT teams have an academic theme where up to five residents might be assigned to a team. In contrast, Albuquerque is affiliated with the University of New Mexico, the only medical school in the state.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[37] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[38] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[39]

To determine whether VISN staff implemented OIG-identified key processes for quality and safety and incorporated them into their activities, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents.

Quality, Safety, and Value Findings and Recommendations

VHA requires staff to collect, analyze, and act on VISN peer review summary data, as appropriate.[40] The OIG did not find evidence the Patient Safety Officer performed these steps for FY 2021 peer review summary data, which could have resulted in missed opportunities for VISN leaders to identify clinical practice trends and determine the need for improvement actions. The OIG found that the previous Patient Safety Officer, who left the position in November 2021, presented FY 2019 quarter four through FY 2020 quarter three peer review summary data to the Quality, Safety, and Value Council in October 2020.

The acting Patient Safety Officer, who was assigned on December 15, 2021, reported being unaware of why the previous Patient Safety Officer did not analyze the FY 2021 summary data. The acting Patient Safety Officer also discussed meeting with the CMO, QMO, and Deputy QMO on February 15, 2022, to consider the issue. The acting Patient Safety Officer said that the departures of the previous QMO, Patient Safety Officer, and Deputy QMO over a two- to three-month period in late 2021 and early 2022 presented challenges to the quality management office. The Deputy QMO acknowledged the OIG's finding as an opportunity to continue improving and stated that staff were focused on rebuilding the quality management program.

[37] VA, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[38] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. VHA rescinded and replaced this directive with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[39] VHA Directive 1100.16.

[40] VHA Directive 1190.

Recommendation 1

1. The Network Director determines the reasons for noncompliance and ensures the Patient Safety Officer collects, analyzes, and acts on peer review summary data.[41]

Veterans Integrated Service Network concurred.

Target date for completion: October 6, 2023

Veterans Integrated Service Network response: The Network Director reviewed the recommendation and did not identify any additional reasons for noncompliance. From March 2022 through July 2023, the designated VISN 22 Quality and Patient Safety Professional, the Acting Risk Management Officer, was responsible for the collection, analysis, and action of Peer Review summary data. In August 2023, VISN 22 appointed a full-time Risk Management Officer who assumed the responsibilities of collecting, analyzing, and acting on Peer Review summary data.

VISN 22 Peer Review summary data was reported to the VISN 22 Quality and Patient Safety (QPS) Council (formerly Quality, Safety and Value (QSV) Council) through governance structure on the following dates: April 2022, May 2022, June 2022, October 2022, January 2023, April 2023, May 2023, and October 2023.

Included are the timeframes of the VISN 22 Peer Review Summary Data that were reported to VISN 22 QPS Council from April 2022 through October 2023.

Month/Year Peer Review Summary Reported to VISN 22 QPS Council *(formerly VISN QSV Council)*	**Peer Review Summary Data Timeframe**
April 2022	FY21Q1- FY21Q4
May 2022	FY22Q1
June 2022	FY22Q2
October 2022	FY21 VISN Comparisons
January 2023	FY21Q4- FY22Q3
April 2023	FY22Q2- FY23Q1
May 2023	FY22 Facility Comparisons and FY23Q1-2
October 2023	FY22 National and VISN 22 Facility Comparisons

[41] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and, therefore, closed the recommendation as implemented before publication of the report.

VISN 22 will continue to ensure that the Risk Management Officer collects, analyzes, acts, and reports on Peer Review summary data to the VISN 22 QPS Council. VISN 22 would like to request closure for this recommendation prior to publication based on supporting evidence provided to OIG.

The Albuquerque Director shared that the facility uses a tiered safety huddle, in combination with a daily management system, to stay abreast of issues throughout the system. A tiered safety huddle involves multiple small work group meetings progressing in a hierarchical method. These meetings start at the team or unit level, climbing through the department and service level, up to the ELT, and then to the VISN. The safety huddle information provided to ELT daily includes safety issues and supports continuous process improvement.

The Greater LA HRO assessment noted that the ELT participates in rounding; however, staff indicated an opportunity for improvement exists in more frequent and inclusive rounding to all areas. In the facility HRO assessment, facility staff expressed a desire for an increase in leadership visibility and engagement to further foster bidirectional communication and promote psychological safety.[42]

[42] As part of the HRO journey, facility leaders and staff participate in a site-specific HRO assessment that provides facility leadership insight by identifying strengths, opportunities, and recommendations. In the weeks following the assessment, facility and VISN leaders participate in an implementation session where they review the assessment and recommendations, and prioritize and create an implementation plan. Following the initial HRO assessment, VISNs and facilities participate in follow-up assessments; the follow-up assessment time frames are not delineated by VHA. At the time of this review, both facilities had plans underway for participation in the required implementation workshop.

Medical Staff Credentialing and Privileging

The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with the VHA policy," which includes the VISN CMO's oversight of credentialing and privileging processes at VISN facilities.[43] "Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA HCS. Credentials are documented evidence of licensure, education, training, experience, or other qualifications."[44]

When certain actions are taken against a physician's license, the senior strategic business partner (previously known as the human resources officer) will make a recommendation to the VISN chief human resources officer, who will then determine whether the physician meets licensure requirements for VA employment.[45] Further, the VISN CMO is required to document a review for any licensed independent practitioner with a history of licensure action such as a "license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application."[46] The VISN CMO must then "make a recommendation to the VHA medical facility that initiated the review process on the appropriateness of continuing the LIP's [licensed independent practitioner's] credentialing application or appointment at the facility."[47]

The OIG inspection team reviewed information for 233 VISN facility physicians hired after January 1, 2021, using publicly available data and VetPro, to determine whether VISN leaders complied with clinical privileging requirements.[48] When reports from the National Practitioner

[43] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Credentialing Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.

[44] VHA Credentialing Directive 1100.20.

[45] VHA Credentialing Directive 1100.20; Standard Operating Procedure – C25 version 3, *Mandatory Reviews of Adverse Licensure, Certification, or Registration Actions*, October 2, 2020. Providers are ineligible for VA appointment if they do not have a full unrestricted license, had a license revoked (without it being fully restored), or surrendered a license (in lieu of revocation); 38 U.S.C. § 7402.

[46] VHA Handbook 1100.19.

[47] For this review, the OIG focused on licensed independent practitioners. A licensed independent practitioner "is an individual permitted by law and the VA medical facility to provide patient care services independently, without supervision or direction, within the scope of the individual's license, and in accordance with privileges granted by the VA medical facility." VHA Credentialing Directive 1100.20; Standard Operating Procedure – 40, *Conducting and Documenting a Chief Medical Officer Credentials Review*, November 9, 2020.

[48] VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, focused on the approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards;" "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file." VHA Handbook 1100.19.

Data Bank or Federation of State Medical Boards appeared to confirm that a physician had a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

- VISN Chief Human Resources Officer's review to determine whether the physician satisfied VA licensure requirements, and
- VISN CMO's review and recommendation for any licensed independent practitioner with a specific licensure or malpractice history.[49]

Medical Staff Credentialing and Privileging Findings and Recommendations

VHA policy states that physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review."[50] The OIG found that one physician, hired in July 2021, had a license placed on probation in March 2012, with the probation terminated in April 2015. The OIG found no evidence of a documented review and recommendation by the CMO prior to the physician's appointment. Failure to conduct the required review could result in inappropriate hiring decisions that jeopardize the quality of patient care.

The CMO reported getting confirmation from the hiring facility that the physician's information was verified in VetPro, and the facility's service chief documented the information in committee minutes. The Medical Staff Privileging Coordinator described generating a weekly VetPro report to identify physicians with adverse actions; however, this case did not appear on any of the weekly reports. The CMO said this provider may not have been on the VetPro report because the adverse action occurred in March 2012, and the provider currently had a full, unrestricted license.

[49] VHA Credentialing Directive 1100.20; Standard Operating Procedure – C40 version 2; "The National Practitioner Data Bank (NPDB) is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers." "Health Workforce Data, Tools, and Dashboards," Health Resources & Services Administration, accessed August 24, 2022, https://data.hrsa.gov/topics/health-workforce/npdb; "The Federation of State Medical Boards represents the state medical and osteopathic regulatory boards – commonly referred to as state medical boards. . . [to] fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals." "About FSMB," Federation of State Medical Boards, accessed August 24, 2022, https://www.fsmb.org/about-fsmb/.

[50] VHA Handbook 1100.19.

Recommendation 2

2. The Chief Medical Officer determines any additional reasons for noncompliance and reviews the credentials file and makes a recommendation on continuing the appointment process for physicians with a potentially disqualifying licensure action.[51]

Veterans Integrated Service Network concurred.

Target date for completion: September 30, 2023

Veterans Integrated Service Network response: The Chief Medical Officer (CMO) reviewed the recommendation and did not identify any additional reasons for noncompliance. The CMO ensures that facilities in VISN 22 adhere to VHA National Standard Operating Procedure (SOP)-C40, *Conducting and Documenting a Chief Medical Officer Credentials Review,* and initiate the CMO process for the review of the credentials file and recommendation on continuing the appointment process for physicians with potentially disqualifying licensure actions identified during initial credentialing. During the annual FY23 Credentialing & Privileging CMO Oversight visits to all eight (8) facilities in VISN 22, the CMO requested the facilities to submit a list of physicians with potentially disqualifying licensure actions from the prior 12 months. There were two (2) physicians initially identified with a potentially disqualifying licensure action, however, upon review by the VISN 22 CMO, both physicians did not meet the criteria for CMO credentials review as per the triggers outlined in VHA National SOP-C40. The CMO will continue to adhere to VHA National SOP-C40 and ensure appropriate review of the credentialing file and recommendation for all physicians with potentially disqualifying licensure actions identified during initial credentialing and initiated by the VISN 22 facilities. VISN 22 would like to request closure for this recommendation prior to publication based on supporting evidence provided to OIG.

[51] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and, therefore, closed the recommendation as implemented before publication of the report.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires facility staff to provide a safe and clean environment of care for veterans, their families, visitors, and employees in accordance with applicable Joint Commission environment of care standards and federal regulatory, applicable VA, and VHA requirements. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff.[52]

To support these efforts, VHA requires VISNs to have a Comprehensive Environment of Care oversight program with a charter.[53] VHA also mandates that VISN leaders ensure staff at network facilities with acute inpatient mental health units submit their Mental Health Environment of Care Checklist review via the Patient Safety Assessment Tool every six months.[54]

The OIG inspection team reviewed relevant documents and interviewed VISN managers.

Environment of Care Findings and Recommendations

The OIG made no recommendations.

[52] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023; VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[53] VHA Directive 1608(1).

[54] "The Mental Health Environment of Care Checklist (MHEOCC) was designed to help facilities identify and address environmental risks for suicide and suicide attempts." The Patient Safety Assessment Tool is a web-based system used for staff to respond to deficiencies found on the Mental Health Environment of Care Checklist and track the implementation of corrective action plans. VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

Mental Health: Suicide Prevention

Suicide prevention remains a top priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides among U.S. adults."[55] Additionally, "among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019."[56]

VHA also requires VISN leaders to appoint mental health staff to serve on the primary governing body, participate on each state's suicide prevention council or workgroup, coordinate activities with state and local mental health systems and community providers, and serve as the VISN representative for the Suicide Prevention Program.[57]

The OIG reviewed relevant documents and interviewed managers to determine whether VISN staff complied with various suicide prevention requirements.

Mental Health Findings and Recommendations

The OIG made no recommendations.

[55] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

[56] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*.

[57] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language as the rescinded 2008 handbook. VHA Directive 1160.07, *Suicide Prevention Program,* May 24, 2021.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care within this VISN, the OIG conducted a detailed review of five clinical and administrative areas and provided two recommendations on issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this VISN. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

While Albuquerque and Greater LA vary in patient population, geographic location, and available services, the OIG identified similar barriers, albeit with different causes. The OIG believes that stable leadership and succession planning, along with ensuring a culture of safety, would facilitate Albuquerque and Greater LA to achieve their goals of providing high quality care to their unique veteran populations.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines two OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Network Director and Chief Medical Officer. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• The Patient Safety Officer collects, analyzes, and acts on peer review summary data.
Medical Staff Credentialing and Privileging	• The Chief Medical Officer reviews the credentials file and makes a recommendation on continuing the appointment process for physicians with a potentially disqualifying licensure action.
Environment of Care	• None
Mental Health: Suicide Prevention	• None

Appendix B: VISN 22 Profile

The table below provides general background information for VISN 22.

Table B.1. Profile for VISN 22
(October 1, 2018, through September 30, 2021)

Profile Element	VISN Data FY 2019*	VISN Data FY 2020†	VISN Data FY 2021‡
Total medical care budget	$5,420,060,167	$6,654,281,199	$7,152,105,350
Number of:			
• Unique patients	523,028	521,747	553,231
• Outpatient visits	6,962,680	6,476,209	7,406,731
Unique employees§	21,893	23,156	23,484
Type and number of operating beds:			
• Community living center	946	946	946
• Domiciliary	614	604	604
• Hospital	1,395	1,355	1,351
Average daily census:			
• Community living center	640	504	405
• Domiciliary	482	289	233
• Hospital	976	872	869

Source: VHA Support Service Center and VA Corporate Data Warehouse.
Note: The OIG did not assess VA's data for accuracy or completeness.
**October 1, 2018, through September 30, 2019.*
†*October 1, 2019, through September 30, 2020.*
‡*October 1, 2020, through September 30, 2021.*
§*Unique employees involved in direct medical care (cost center 8200).*

Appendix C: Social Determinants of Health Unique to Each Facility

Figure C.1. *Social Determinants of Health.*

Source: Centers for Disease Control and Prevention (CDC) Social Determinants of Health.

Albuquerque

Albuquerque is designated as complexity level 1b and is the only VHA facility in the state.[1] The primary facility, located in Albuquerque, and its 13 CBOCs, some located in remote areas of New Mexico and western Colorado, serve approximately 149,000 veterans including approximately 4,300 indigenous veterans.[2] New Mexico has a Hispanic population of about 50 percent and a Native American population of 11 percent. There are 23 Native American tribes

[1] The complexity model rates facilities as 1a, 1b, 1c, 2, or 3, with facilities rating 1a being the most complex and those rated 3 the least complex. A level 1b facility has "medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs." VHA Office of Productivity, Efficiency, and Staffing (OPES), "Facility Complexity Level Model Fact Sheet," January 28, 2021.

[2] "VHA New Mexico health care: Locations," VA, accessed February 16, 2023, https://www.va.gov/new-mexico-health-care/locations/. There are 13 CBOC locations in New Mexico and one in southwestern Colorado under the New Mexico VHA HCS; "National Center for Veterans Analysis and Statistics: Veteran Population," VA, accessed January 23, 2023, https://www.va.gov/vetdata/Veteran_Population.asp.

located in New Mexico including 19 Pueblos, 3 Apache tribes, and the Navajo Nation.[3] Albuquerque "partners with Indian Health Service and Tribal Healthcare Organizations for provision of direct care to eligible American Indian Veterans by way of agreements that allows reimbursement by NMVAHCS [New Mexico VA Healthcare System]."[4]

Homelessness, addiction, poverty, and the rurality of the state are factors identified by Albuquerque leadership as cultural challenges. The former Albuquerque Chief of Staff (COS), in an interview, stressed the importance of being culturally sensitive while delivering care to those veterans residing in the sovereign indigenous nations throughout the region. For example, for certain senior positions in the Navajo Nation, a gesture of respect is to speak to Native American veterans in their native Navajo language, often requiring an interpreter.

Facility leaders also identified that, during the period reviewed, the high proportion of Native Americans "severely affected" by COVID-19 was an additional community challenge for Albuquerque. One example, provided by the former COS, involved a Navajo patient who resided on tribal property in a common large family dwelling that had the potential to house several family members. Additionally, it was reported that traditional Navajo teaching involves a ritual of burning the dwelling in which an individual dies.[5] Finally, according to the former COS, traditional beliefs, such as this, were factors the facility had to take into consideration when deciding whether to discharge a patient with COVID-19 to home care. In this situation, the facility had to consider the effect a death might have on extended family members residing in the same dwelling.

For indigenous veterans living on tribal land or in remote rural areas, the Facility Director identified treatment challenges related to patient access to VHA care. Staff also described various staffing challenges for remote rural areas. According to leaders, in remote areas, there is either a scarcity of community providers, or existing providers may refuse to participate in community care because of reimbursement issues. A staff member also described increased lengths of stay for patients because of limited community resources, as well as few contracted facilities for skilled needs. In response, the VISN developed the goal of optimizing care to ensure the indigenous population residing on reservations are provided the same resources as those veterans not residing on tribal property.

[3] "History," New Mexico Indian Affairs Department, accessed on October 10, 2023, https://www.iad.state.nm.us/about-us/history/.

[4] NMVAHCS has a joint venture partnership with the 377 Medical Group/Kirtland Air Force Base, and partners with Indian Health Service and Tribal Healthcare Organizations for provision of direct care to eligible American Indian Veterans by way of agreements that allow reimbursement by NMVAHCS for care delivered by IHS/Tribal Health Organizations. Accessed on January 6, 2023. (This website is not publicly accessible.)

[5] Joe Oliveto, "Navajo Beliefs About Death, Burials & Funerals Explained," *Cake* (blog), updated September 20, 2021, accessed January 5, 2023, https://www.joincake.com/blog/navajo-beliefs-about-death/.

To improve the quality of care for indigenous veterans, Congress enacted the Indian Health Improvement Act. To implement the Act, VHA and the Indian Health Service entered into a Memorandum of Understanding that expands VHA's capacity to serve veterans in extremely rural areas.[6] The former facility COS told the OIG that VHA engaged in a Memorandum of Understanding with the Public Health Service. Consistent with that Memorandum of Understanding, Public Health Service providers who desire work in rural areas are connected with VHA to provide health care to veterans.[7]

The OIG learned from facility leaders that, at the facility level, Albuquerque's response to these challenges, based on the identified social determinants, includes an increase in its use of telehealth and VA Video Connect programs, outreach, hiring incentives, and hiring gap providers to travel to rural CBOCs.[8]

Greater LA

Greater LA is a 1a complexity facility; the OIG was told that the high cost of living in Greater LA affects the recruitment and retention of facility staff.[9] During interviews, the OIG was told staff often engage in long commutes to the facility in order to live in a more affordable neighborhood. Greater LA is implementing incentives for the recruitment and retention of nursing staff, including financial bonuses, a debt reduction program, and flexible work hours.

During the period reviewed, there were approximately 22,000 homeless veterans who were associated with Greater LA. According to a facility leader, the facility serves "the largest proportion of patients treated that identify as homeless or underhoused." VHA has implemented multiple initiatives to address homelessness among veterans, including membership in the US Interagency Council on Homelessness and working with the US Housing and Urban Development to offer affordable housing options. In addition, Greater LA provided over 100 tiny shelters on the Greater LA property as temporary housing. According to the Facility Director, there is a master plan to offer housing and other supportive services for the homeless on the

[6] The Indian Health Improvement Act, 25 U.S.C. §§ 1645, provides the legal foundation for the provision of health care to American Indians and Alaska Natives. The Memorandum Of Understanding between VHA and the US Department of Health and Human Services, Indian Health Service (October 1, 2021) provides a plan for the coordination, collaboration, and resources sharing between the two agencies.

[7] "Memorandum of Understanding Between the United States Department of Veterans Affairs Veterans Health Administration and United States Department of Health and Human Services Indian Health Service," accessed November 6, 2023, https://department.va.gov/administrations-and-offices/tribal-government-relations/access/.

[8] Gap providers are full-time VHA employees who provide coverage for assigned Patient Aligned Care Team (PACT) providers.

[9] VHA OPES, "Facility Complexity Level Model Fact Sheet."

northern part of Greater LA's campus.[10] Additionally, Greater LA provides counseling and programming to homeless veterans and has established a homeless primary care clinic.

According to one facility leader, the veteran population without homes impacts the facility's overall focus of providing veteran care. The Facility Director described caring for the homeless population as "all-encompassing," and an "additional piece here that that doesn't exist elsewhere." The deputy chief of staff described in a questionnaire response that Greater LA faces a "unique challenge" in determining its primary mission based on the homeless population.

On April 11, 2023, VA announced the opening of two buildings at Greater LA that will provide 120 units of permanent supportive housing for homeless and at-risk veterans and their families.[11]

An opportunity exists for VISN 22 to continue providing support to Greater LA to address challenges with caring for those veterans who are homeless.

The facility's primary focus, according to the deputy chief of staff, continues to be providing for the clinical care of all veterans. However, there is a concern that the "cost" of so much attention going to facility infrastructure changes, in an effort to assist in resolving the veteran homeless issues, has the potential to divert attention provided to clinical care. Other facility leaders did not raise this concern, and the OIG did not identify any adverse outcomes based on this review.

[10] In 2018, and in 2021, the OIG conducted an audit of VA's management of land use to determine in part the progress made following the implementation of the master plan to provide housing and buildings for supportive services for veterans on the West Los Angeles Campus. While finding that VA was making progress on this issue, VA did not meet its initial milestone to provide 490 permanent supportive housing units. The OIG did not make any recommendations associated with the issue. VA OIG, *VA's Management of Land Use under the West Los Angeles Leasing Act of 2016: Five-Year Report*, Report No. 20-03407-253, September 29, 2021.

[11] VA, "VA Opens Two Buildings to Provide 120 Units of Housing for Homeless and At-risk Veterans on West LA Campus," press release, April 11, 2023, https://www.va.gov/greater-los-angeles-health-care/news-releases/va-opens-two-buildings-to-provide-120-units-of-housing-for-homeless-and-at-risk-veterans-on-west-la/.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 21, 2023

From: Interim Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Comprehensive Healthcare Inspection of Veterans Integrated Service Network 22: VA Desert Pacific Healthcare Network

To: Director, Office of Healthcare Inspections (54CH04)

Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) report, Comprehensive Healthcare Inspection of Veterans Integrated Service Network 22: VA Desert Pacific Healthcare Network.
2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the findings, recommendations and submitted VISN 22 action plans.
3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(Original signed by:)

Steven E. Braverman, MD
VISN 22 Interim Network Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Kristen Leonard, DNP, RN Brandon LeFlore-Nemeth MBA, BS Tishanna McCutchen, DNP, MSPH Chastity Osborn, DNP, RN Dawn Rubin, JD Glenn Schubert, MPH Laura Snow, LCSW, MHCL Randall Snow, JD David Vibe, MBA Thomas Wong, DO
Other Contributors	Kaitlyn Delgadillo, BSPH Reynelda Garoutte, MHA, BSN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Adam Hummel, MPPA Sarah Mainzer, JD, BSN Barbara Mallory-Sampat, JD, MSN Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Natalie Sadow, MBA Caitlin Sweany-Mendez, MPH Yurong Tan, PhD Elizabeth K. Whidden, MS, APRN

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Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 22: VA Desert Pacific Healthcare Network

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
- Arizona: Mark Kelly, Kyrsten Sinema
- California: Laphonza Butler, Alex Padilla
- Colorado: Michael Bennet, John Hickenlooper
- New Mexico: Martin Heinrich, Ben Ray Luj?n

US House of Representatives
- Arizona: Andy Biggs, Juan Ciscomani, Eli Crane, Ruben Gallego, Paul Gosar, Ra?l Grijalva, Debbie Lesko, David Schweikert, Greg Stanton
- California: Pete Aguilar, Nanette Diaz Barrag?n, Julia Brownley, Ken Calvert, Salud Carbajal, Tony C?rdenas, Judy Chu, Lou Correa, Mike Garcia, Robert Garcia, Jimmy Gomez, Darrell Issa, Sara Jacobs, Sydney Kamlager-Dove, Young Kim, Mike Levin, Ted Lieu, Grace F. Napolitano, Jay Obernolte, Jimmy Panetta, Scott Peters, Katie Porter, Raul Ruiz, Linda S?nchez, Adam Schiff, Brad Sherman, Michelle Steel, Mark Takano, Norma Torres, David Valadao, Juan Vargas, Maxine Waters
- Colorado: Lauren Boebert, Ken Buck
- New Mexico: Teresa Leger Fernandez, Melanie Stansbury, Gabe Vasquez

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