



# US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

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## VETERANS HEALTH ADMINISTRATION

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# Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington

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**Figure 1.** Mann-Grandstaff VA Medical Center in Spokane, Washington.

Source: <https://www.va.gov/spokane-health-care/locations/> (accessed January 5, 2023).

## Abbreviations

ADPCS/NE	Associate Director for Patient Care Services/Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Mann-Grandstaff VA Medical Center, which includes multiple outpatient clinics in Idaho, Montana, and Washington. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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 facility approximately 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 five areas of clinical and administrative operations:

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

The OIG initiated an unannounced inspection of the Mann-Grandstaff VA Medical Center during the week of December 12, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

The Mann-Grandstaff VA Medical Center was the first Veterans Health Administration facility to implement the new electronic health record (Oracle Cerner) with a go-live date of October 24, 2020.<sup>1</sup> The Medical Center Director reported that medical center staff and veterans have been in an environment of continuous change and adaptation during the extended transition

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<sup>1</sup> VA OIG, [Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington](#), Report No. 21-00656-110, March 17, 2022. "VA's Electronic Health Record Modernization (EHRM) program is an effort to replace the department's current EHR [electronic health record]...with a new commercial solution." VA selected Cerner Corporation as its electronic health record vendor. "What is the Electronic Health Record Modernization program?," VA EHR Modernization, accessed December 22, 2022, <https://digital.va.gov/ehr-modernization/resources/frequently-asked-question/>.

to the new electronic health record. The OIG has published several reports related to Oracle Cerner and the resulting issues at the medical center.<sup>2</sup>

## Results Summary

The OIG noted opportunities for improvement and issued six recommendations to the Medical Center Director in the following areas of review: Quality, Safety, and Value; Environment of Care; and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. 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 systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 21.

## VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 24–25, and the responses within the body of the report for the full text of the directors’ comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.



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

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<sup>2</sup> VA OIG, [Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington](#), Report No. 21-00781-108, March 17, 2022; VA OIG, [Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington](#), Report No. 21-00781-109, March 17, 2022; VA OIG, [Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington](#); VA OIG, [Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington](#), Report No. 21-03020-168, June 1, 2022.

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## Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report’s evaluation of the quality of care delivered in the inpatient and outpatient settings of the Mann-Grandstaff VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so they can make informed decisions to improve care.<sup>1</sup>

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.<sup>2</sup> Effective leadership has been cited as “among the most critical components that lead an organization to effective and successful outcomes.”<sup>3</sup>

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:<sup>4</sup>

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

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<sup>1</sup> VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

<sup>2</sup> 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): 13, <https://doi.org/10.1136/bmjopen-2014-005055>.

<sup>3</sup> 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>.

<sup>4</sup> CHIP site visits addressed these processes during fiscal year 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years’ focus areas.

## Methodology

The Mann-Grandstaff VA Medical Center also provides care through multiple outpatient clinics in Idaho, Montana, and Washington. General information about the medical center can be found in appendix B.

The OIG inspected the Mann-Grandstaff VA Medical Center beginning the week of December 12, 2022.<sup>5</sup> During the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline for further review.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.<sup>6</sup> 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 medical center leaders complete corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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.

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<sup>5</sup> The OIG's last comprehensive healthcare inspection of the Mann-Grandstaff VA Medical Center occurred in September 2020. The Joint Commission performed a hospital review in March 2022.

<sup>6</sup> Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

## Results and Recommendations

### Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.<sup>7</sup> High-impact leaders should be person-centered and transparent, engage front-line staff members, have a “relentless focus” on their organization’s vision and strategy, and “practice systems thinking and collaboration across boundaries.”<sup>8</sup> 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.<sup>9</sup>

To assess this medical center’s leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Oracle Cerner Electronic Health Record Implementation
4. Employee satisfaction
5. Patient experience
6. Identified factors related to possible lapses in care and medical centers leaders’ responses

### Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Services/Nurse Executive (ADPCS/NE), and Associate Director. The Chief of Staff and ADPCS/NE oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for over one year. The Chief of Staff, ADPCS/NE, and Associate Director were appointed in 2021. The Director had the longest tenure at over five years. To help assess executive leaders’ engagement, the OIG

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<sup>7</sup> Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

<sup>8</sup> Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

<sup>9</sup> Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care*, Institute for Healthcare Improvement White Paper, 2017.

interviewed the Director, Chief of Staff, ADPCS/NE, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

## **Budget and Operations**

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of \$467,172,937 had increased by approximately 8 percent compared to the previous year's budget of \$430,867,183.<sup>10</sup> The Director reported a projected \$30 million deficit in FY 2023, primarily due to the \$28 million needed to remedy Oracle Cerner-related concerns that Veterans Health Administration (VHA) did not fund.<sup>11</sup>

## **Oracle Cerner Electronic Health Record Implementation**

The medical center was the first VHA facility to go live with Oracle Cerner, in October 2020. The OIG has published several reports related to Oracle Cerner and the resulting issues at the medical center.<sup>12</sup> The Director reported that over 250 staff members were working solely on Oracle Cerner issues so providers could deliver safe patient care. Additionally, because of deficiencies discovered after implementation of the new electronic health record, the Director stated that staff had to review over 31,000 misdirected clinical orders to ensure patients received the care their providers prescribed. At the time of the OIG inspection in December 2022, the Director estimated there were 700 orders left to review. The Chief of Medicine reported that more than two years after the implementation, the Medicine service was functioning at 85 percent of pre-Oracle Cerner efficiency.

## **Employee Satisfaction**

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."<sup>13</sup> Although the OIG recognizes that employee

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<sup>10</sup> Veterans Health Administration (VHA) Support Service Center.

<sup>11</sup> "VA's Electronic Health Record Modernization (EHRM) program is an effort to replace the department's current EHR [electronic health record]...with a new commercial solution." VA selected Cerner Corporation as its electronic health record vendor. "What is the Electronic Health Record Modernization program?," VA EHR Modernization, accessed December 22, 2022, <https://digital.va.gov/ehr-modernization/resources/frequently-asked-question/>. VA OIG, *Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00656-110, March 17, 2022.

<sup>12</sup> VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-108, March 17, 2022; VA OIG, *Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-109, March 17, 2022; VA OIG, *Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*; VA OIG, *Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-03020-168, June 1, 2022.

<sup>13</sup> "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

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 medical center leaders.

To assess employee viewpoints, the OIG reviewed results from VA’s All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal. Table 1 provides relevant survey results for VHA and the medical center over time. The Director reported encouraging staff to speak up about adverse events and enter them in the VA patient safety reporting system as appropriate. The Associate Director articulated that leaders and staff were working to increase patient safety reporting.

**Table 1. All Employee Survey Question:  
Ability to Disclose a Suspected Violation  
(FYs 2020 through 2022)**

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Mann-Grandstaff VA Medical Center	3.9	3.9	3.9

*Source: VA All Employee Survey (accessed October 18, 2022).*

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

## Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients’ healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.<sup>14</sup> The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from October 1, 2019, through July 31, 2022. Table 2 provides survey results for VHA and the medical center over time.

Patient satisfaction scores for the medical center were higher than VHA averages, except for specialty care in FY 2021 and primary care in FY 2022. Survey results indicated that patients’ satisfaction with their primary care experiences decreased over all three years. Results also revealed that patients’ satisfaction with their inpatient experiences significantly decreased in FY 2022, whereas their satisfaction with specialty care increased. Leaders reported believing that decreased staff morale led to lower patient satisfaction scores. The Chief of Staff stated that employee morale and retention and patient access decreased in FY 2022 because of Oracle

<sup>14</sup> “Patient Experiences Survey Results,” VHA Support Service Center.

Cerner issues. To increase patient satisfaction, the Chief of Staff shared that primary care teams had begun expanding on-site appointments because patients preferred seeing providers in person.

The ADPCS/NE stated that in FY 2022, some patients had extended lengths of stay due to limited availability of community hospital beds. Additionally, the ADPCS/NE said that lack of secure messaging tools in Oracle Cerner limited patients’ access to their providers, which may have influenced the lower scores in primary care. Furthermore, the ADPCS/NE shared that until recently, Oracle Cerner did not offer a way for patients to renew medications online, which may have frustrated many patients.

**Table 2. Survey of Healthcare Experiences of Patients  
(October 1, 2019, through July 31, 2022)**

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: <i>Would you recommend this hospital to your friends and family?*</i>	69.5	86.8	69.7	93.8	68.5	69.6
Patient-Centered Medical Home: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	82.5	84.9	81.9	82.6	81.0	74.2
Specialty Care: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	84.8	85.0	83.3	69.4	82.0	89.9

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 7, 2022).

\*The response average is the percent of “Definitely yes” responses.

†The response average is the percent of “Very satisfied” and “Satisfied” responses.

## Identified Factors Related to Possible Lapses in Care and Medical Center Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.<sup>15</sup> According to The Joint Commission's (TJC's) standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.<sup>16</sup> A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.<sup>17</sup>

“A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).”<sup>18</sup> Additionally, an institutional disclosure is “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.”<sup>19</sup> Lastly, a large-scale disclosure is “a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue.”<sup>20</sup> To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.<sup>21</sup>

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<sup>15</sup> Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

<sup>16</sup> TJC, *Standards Manual*, E-edition, July 1, 2022. A culture of safety is “the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management.” “Hospital Survey on Patient Safety Culture: User's Guide,” Agency for Healthcare Research and Quality, July 2018, accessed September 23, 2021, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf>.

<sup>17</sup> Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

<sup>18</sup> TJC, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates TJC's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

<sup>19</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

<sup>20</sup> VHA Directive 1004.08.

<sup>21</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The new directive contains similar language regarding patient safety as the rescinded handbook.)

The OIG requested sentinel events and institutional and large-scale disclosures that occurred from October 1, 2021, through September 30, 2022, and reviewed the information staff provided. The Director reported receiving notification of sentinel events from the patient safety managers, service chiefs, and executive leaders. A patient safety manager reported using a VHA matrix to classify sentinel events. The Chief of Staff stated that patient safety employees identified deaths and incidents of permanent or severe harm as sentinel events and discussed them with the Director and Chief of Staff. The Chief, Quality, Safety & Value said that a provider reviews all adverse events that cause patient harm.

### **Leadership and Organizational Risks Findings and Recommendations**

The OIG recognizes that implementation of the Oracle Cerner electronic health record created widespread challenges to patient safety, staff morale, budget, and patient satisfaction. The OIG made no recommendations.



## Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.<sup>22</sup> To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain TJC accreditation.<sup>23</sup> Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.<sup>24</sup>

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.<sup>25</sup> According to TJC's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.<sup>26</sup>

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.<sup>27</sup> Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."<sup>28</sup> 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.<sup>29</sup>

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports.

## Quality, Safety, and Value Findings and Recommendations

VHA requires an executive-level medical committee to review the Peer Review Committee's summary analysis quarterly and use these data, such as the volume or level of peer reviews, to

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<sup>22</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

<sup>23</sup> VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

<sup>24</sup> VHA Directive 1100.16.

<sup>25</sup> VHA Handbook 1050.01; VHA Directive 1050.01.

<sup>26</sup> TJC, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

<sup>27</sup> A peer review is a "critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

<sup>28</sup> VHA Directive 1190.

<sup>29</sup> VHA Directive 1190.

determine possible actionable items.<sup>30</sup> The OIG reviewed the Health Care Delivery Council’s meeting minutes, the Peer Review Committee summary analysis data, and peer reviews for FY 2022 and found that summary analysis data were inaccurate, and the Peer Review Committee did not present the data to the council for one quarter. Specifically, the OIG found that the Peer Review Committee’s summary analyses contained inaccurate peer review levels, level changes, and number of peer reviews completed. Further, the OIG noted that meeting minutes did not contain evidence the council used the data to define tasks or develop action plans to address issues.<sup>31</sup> The inaccurate quarterly summary data may have resulted in the council’s failure to identify deficient clinical practice trends, determine the need for further action, and monitor the effectiveness of quality improvement initiatives.

The Risk Manager reported compiling the summary analyses but was unable to explain the inaccuracies. The Risk Manager further reported submitting the analyses to the council in all four quarters but could not explain why it was missing from one quarter’s meeting minutes. The Deputy Chief of Staff stated the council discussed peer review statistics during the meetings but acknowledged the meeting minutes were incomplete.

## Recommendation 1

1. The Medical Center Director ensures the Peer Review Committee submits accurate peer review summary analysis data quarterly to the Health Care Delivery Council.

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<sup>30</sup> The initial reviewer and peer review committee assign a level of care “in assessing the clinical decisions and actions of the clinician who is the subject of a Peer Review.” A peer review is assigned a Level 1 when “most experienced and competent clinicians would have managed the case in a similar manner;” a Level 2 when “most experienced and competent clinicians might have managed the case differently but it remains within the standard of care;” and a Level 3 when “most experienced and competent clinicians would have managed the case differently.” VHA Directive 1190.

<sup>31</sup> The medical center’s executive-level medical committee was formerly called the Clinical Executive Council but was renamed the Health Care Delivery Council in June 2022.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: Quarterly audits of the Health Care Delivery Council minutes will be completed by the Chief, Quality, Safety & Value to verify that required elements of the peer review summary analysis data is reviewed and reported. The denominator value will be calculated by the total number of peer review cases presented to the Peer Review Committee. The numerator value will be the total number of peer review cases that were accurately presented to the Peer Review Committee and the Health Care Delivery Council. The three data categories that will be monitored are the number of peer reviews, the number of correct level changes and the number of accurate final levels. The audit data will be reported to the Quality and Safety Council chaired by the Medical Center Director and Chief, Quality, Safety & Value. Quarterly reporting will continue until a minimum compliance of 90 percent is sustained for two consecutive quarters.

## Recommendation 2

2. The Medical Center Director ensures the Health Care Delivery Council reviews the Peer Review Committee's summary analysis quarterly and determines actionable items.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The medical center established and implemented a new standard operating procedure for protected peer reviews as well as a new committee charter for the Peer Review Committee. The Peer Review Committee will present a summary analysis quarterly to the Health Care Delivery Council. The Health Care Delivery Council will review the summary analysis and provide any recommendations as needed. The Health Care Delivery Council analysis and any identified follow-up actions will be captured in the council minutes, though the council may not always identify further actions are needed based on the review. Quarterly audits of the Health Care Delivery Council minutes will be completed by the Chief, Quality, Safety & Value to ensure membership is reviewing and, if warranted, recommending any follow-up actions related to the Peer Review Committee's summary analysis. The denominator value will be calculated as the number of quarters of Health Care Delivery Council minutes and the numerator value will be calculated as the number of Health Care Delivery Council minutes with documented evidence of the committee's review of the summary analysis and determination of any necessary actionable items. The audit data will be reported quarterly to the Quality and Safety Council chaired by the Medical Center Director and Chief, Quality, Safety & Value. Quarterly reporting will continue until a minimum compliance of 90 percent is sustained for two consecutive quarters.

## Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently.”<sup>32</sup> These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care “without supervision or direction, within the scope of the individual’s license, and in accordance with individually-granted clinical privileges.”<sup>33</sup>

Privileges need to be specific and based on the individual practitioner’s clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP’s credentials and service chief’s recommendation to determine whether “clinical competence is adequately demonstrated to support the granting of the requested privileges,” and submits the final recommendation to the facility director.<sup>34</sup> LIPs are granted clinical privileges for a limited time and must be repriviledged prior to their expiration.<sup>35</sup>

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs’ professional performance. The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP’s performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.<sup>36</sup>

VHA’s credentialing process involves the assessment and verification of healthcare practitioners’ qualifications to provide care and is the first step in ensuring patient safety.<sup>37</sup> Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the chief of staff. VHA also requires facilities to have credentialing

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<sup>32</sup> 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 Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

<sup>33</sup> VHA Handbook 1100.19.

<sup>34</sup> VHA Handbook 1100.19.

<sup>35</sup> VHA Handbook 1100.19.

<sup>36</sup> VHA Handbook 1100.19.

<sup>37</sup> VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.<sup>38</sup>

The OIG interviewed key managers and selected and reviewed the privileging folders of 28 medical staff members who underwent initial privileging or reprivileging during FY 2022.

### **Medical Staff Privileging Findings and Recommendations**

The OIG made no recommendations.

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<sup>38</sup> Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, “Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020,” December 16, 2020.

## Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved.<sup>39</sup> The goal of VHA’s environment of care program is to ensure “a safe, clean health care environment that provides the highest standards in the health care setting.”<sup>40</sup> The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.<sup>41</sup>

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.<sup>42</sup>

During the OIG’s review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected five patient care areas:

- Community living center (Cedar Grove)
- Intensive care unit
- Medical/surgical inpatient care unit
- Primary care clinic
- Urgent care center

## Environment of Care Findings and Recommendations

The Occupational Safety and Health Administration requires that “work practice controls shall be used to eliminate or minimize employee exposure” to potentially contaminated materials.<sup>43</sup> It

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<sup>39</sup> VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (VHA amended this directive September 7, 2023.)

<sup>40</sup> VHA Directive 1608.

<sup>41</sup> VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

<sup>42</sup> VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013; VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023.)

<sup>43</sup> Occupational Safety and Health Standards, *Bloodborne Pathogens*, 29 C.F.R. § 1910.1030(d)(2)(i). “Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.” 29 C.F.R. § 1910.1030(b).

also states that “eating [and] drinking...are prohibited in work areas where there is a reasonable likelihood of occupational exposure.”<sup>44</sup> In the urgent care center and the medical/surgical intensive care unit, the OIG found food and drinks and saw staff eating on portable hallway computer workstations. This increased the risk of staff exposure to the presence of blood or other potentially infectious materials on items or surfaces. The Infection Prevention Nurse attributed the noncompliance to staff convenience and reported believing patient care demands typically prevented staff from leaving their work areas for breaks.

### Recommendation 3

3. The Medical Center Director ensures employees comply with safe work practices to eliminate or minimize exposure to potentially infectious materials.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The nurse managers of the medical/surgical intensive care unit and the urgent care center will conduct training with staff on requirements prohibiting food and drink consumption by staff in patient care areas. Training will be conducted for all shifts and attendance will be taken. Two training events occurred in September 2023. Additionally, an all-staff email will be sent out summarizing the training.

Random observation audits of the medical/surgical intensive care unit and urgent care center will be conducted by the Quality Safety and Value Specialist to ensure staff are not eating or drinking in patient care areas. There will be 15 observations per month in the medical/surgical intensive care unit and 15 observations in the urgent care center. The denominator will be the total number of observations and the numerator will be the number of observations without food or drink in prohibited areas. The Quality Safety and Value Specialist will report the audit data monthly to the Quality and Safety Council chaired by the Medical Center Director and Chief, Quality, Safety & Value. Monthly reporting will continue until a minimum compliance of 90 percent is sustained for six consecutive months.

VHA requires the medical center director to ensure “access to clean/sterile storerooms is restricted to authorized personnel.”<sup>45</sup> Additionally, TJC requires that “the hospital reduces the risk of infections associated with medical equipment, devices, and supplies.”<sup>46</sup> In the

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<sup>44</sup> Occupational Safety and Health Standards, *Bloodborne Pathogens*, 29 C.F.R. § 1910.1030(d)(2)(ix).

“Occupational exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.” 29 C.F.R. § 1910.1030(b).

<sup>45</sup> VHA Directive 1761.

<sup>46</sup> TJC, *Standards Manual*, E-dition, IC.02.02.01, January 1, 2022.

medical/surgical intensive care unit, the OIG found an unrestricted tub room being used as both a patient bathroom and clean equipment storage area. This potentially exposed patients and clean equipment to infectious material. The Inpatient Unit Nurse Manager reported there was nowhere else within the unit to store the clean equipment for quick access.

#### **Recommendation 4**

4. The Medical Center Director ensures the Inpatient Unit Nurse Manager for the medical/surgical intensive care unit restricts access to clean and sterile storerooms to authorized personnel.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: All clean equipment was removed from the tub room, A535, as of September 21, 2023. The Inpatient Unit Nurse Manager will educate departmental staff that the tub room will not be used for storage. Random observation audits will be completed by the Quality Safety and Value Specialist to ensure no equipment is being stored in room A535. There will be 15 observations per month. The denominator will be the total number of observations per month and the numerator will be the total number of monthly observations without equipment stored in room A535. The audit data will be reported to the Quality and Safety Council, which is chaired by the Medical Center Director and Chief, Quality, Safety & Value. Monthly reporting will continue until a minimum compliance of 90 percent is sustained for six consecutive months.



## Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.<sup>47</sup> Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.<sup>48</sup> The suicide rate for veterans was higher than for nonveteran adults during 2020.<sup>49</sup> “Congress, VA, and stakeholders continue to express concern over seemingly limited progress made...to reduce veteran suicide.”<sup>50</sup>

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.<sup>51</sup> VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.<sup>52</sup>

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.<sup>53</sup>

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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<sup>47</sup> VA Secretary memo, “Agency-Wide Required Suicide Prevention Training,” October 15, 2020.

<sup>48</sup> “Preventing Suicide,” Centers for Disease Control and Prevention, accessed March 14, 2022, [https://www.cdc.gov/suicide/facts/index.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fsuicide%2Ffastfact.html](https://www.cdc.gov/suicide/facts/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fsuicide%2Ffastfact.html).

<sup>49</sup> VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

<sup>50</sup> Congressional Research Service, “Veteran Suicide Prevention,” IF11886 version 2, July 29, 2021.

<sup>51</sup> Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy),” November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy),” November 23, 2022.)

<sup>52</sup> Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);” Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Suicide Behavior and Overdose Reporting,” July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Update to Suicide Behavior and Overdose Reporting,” May 9, 2023.)

<sup>53</sup> VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. “Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year.” VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

## Mental Health Findings and Recommendations

VHA requires the suicide prevention coordinator to report suicide-related events monthly to “local mental health leadership and quality management.”<sup>54</sup> The OIG found that quality management staff did not provide evidence the Suicide Prevention Coordinator reported suicide-related events to them in FY 2022, and mental health leaders only supplied evidence the coordinator reported in June, August, and September 2022. Infrequent reporting of suicide-related events could limit leaders’ oversight and may result in missed opportunities for them to improve suicide prevention practices.

The Deputy Chief of Staff described challenges providing consistent coverage for the suicide prevention coordinator role and explained various employees temporarily served in the position during FY 2022, which may have led to missed reporting. The acting Chief, Behavioral Health Service, detailed to the position on May 6, 2022, described receiving monthly reports via email but being unable to provide evidence for more than three months. Additionally, the Chief, Quality, Safety & Value could not explain why staff acting in the suicide prevention coordinator position did not report suicide-related events to quality management staff.

### Recommendation 5

5. The Medical Center Director ensures the Suicide Prevention Coordinator reports suicide-related events monthly to local mental health leaders and quality management staff.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The Suicide Prevention Coordinator will report the suicide related events monthly to the Quality and Safety Council which is co-chaired by the Medical Center Director and Chief, Quality, Safety & Value. The Chief of Behavioral Health is a voting member of the Quality and Safety Council. These reports will be captured in the Quality and Safety Council minutes as evidence of completion.

A monthly audit will be completed by the Chief, Quality, Safety & Value to achieve a minimum of 90 percent compliance for six consecutive months. Percentage will be calculated as follows: denominator value of total months and a numerator value of the number of months with the suicide prevention presentation of suicide related events to the Quality and Safety Council for which the Medical Center Director and Chiefs of Quality, Safety & Value and Behavioral Health attend or sign the minutes.

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<sup>54</sup> VHA Directive 1160.07.

VHA requires providers to complete Comprehensive Suicide Risk Evaluations following patients' positive suicide risk screens.<sup>55</sup> The OIG estimated that providers did not complete the evaluation after a positive screen for 54 (95% CI: 40 to 68) percent of patients, which is statistically significantly above the OIG's 10 percent deficiency benchmark.<sup>56</sup> Failure to evaluate patients' suicide risk could result in missed opportunities for staff to implement suicide safety plans. The acting Chief, Primary Care Service reported believing staff had relied on the electronic health record's (Oracle Cerner's) automated provider notification process, which was discovered to have a 48-hour lag in FY 2022 in automatically sending screening results to the provider. This leader also stated that reliance on automated notifications instead of warm handoffs (in-person notifications) between the initial screener and provider may have contributed to low compliance.

## Recommendation 6

6. The Medical Center Director ensures providers complete Comprehensive Suicide Risk Evaluations following patients' positive suicide risk screens.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The Suicide Prevention Coordinator will audit all electronic health records containing a positive Columbia-Suicide Severity Risk Screening monthly for completion of a Comprehensive Suicide Risk Evaluation. Measure of compliance will use number of charts with a positive Columbia-Suicide Severity Risk Screen as the denominator and the number of subsequently completed Comprehensive Suicide Risk Evaluations as the numerator. A minimum compliance of 90 percent will be achieved for six consecutive months. The Suicide Prevention Coordinator will present the monthly audit numerator, denominator, and compliance percentage monthly to the Quality and Safety Council, which is co-chaired by the Medical Center Director.

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<sup>55</sup> Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

<sup>56</sup> A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

## **Report Conclusion**

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided six recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

## Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines six OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Medical Center Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

**Table A.1. Summary Table of Recommendations**

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> <li>• None</li> </ul>
Quality, Safety, and Value	<ul style="list-style-type: none"> <li>• The Peer Review Committee submits accurate peer review summary analysis data quarterly to the Health Care Delivery Council.</li> <li>• The Health Care Delivery Council reviews the Peer Review Committee's summary analysis quarterly and determines actionable items.</li> </ul>
Medical Staff Privileging	<ul style="list-style-type: none"> <li>• None</li> </ul>
Environment of Care	<ul style="list-style-type: none"> <li>• Employees comply with safe work practices to eliminate or minimize exposure to potentially infectious materials.</li> <li>• The Inpatient Unit Nurse Manager for the medical/surgical intensive care unit restricts access to clean and sterile storerooms to authorized personnel.</li> </ul>
Mental Health: Suicide Prevention Initiatives	<ul style="list-style-type: none"> <li>• The Suicide Prevention Coordinator reports suicide-related events monthly to local mental health leaders and quality management staff.</li> <li>• Providers complete Comprehensive Suicide Risk Evaluations following patients' positive suicide risk screens.</li> </ul>

## Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) affiliated medical center reporting to VISN 20.<sup>1</sup>

**Table B.1. Profile for Mann-Grandstaff VA Medical Center (668)  
(October 1, 2019, through September 30, 2022)**

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	\$412,180,440	\$430,867,183	\$467,172,937
Number of:			
• Unique patients	35,485	35,853	36,524
• Outpatient visits	345,702	328,766	315,430
• Unique employees§	1,085	1,156	1,192
Type and number of operating beds:			
• Community living center	34	34	34
• Medicine	22	22	22
• Mental health <sup>1</sup>	0	0	0
• Surgery	2	2	2
Average daily census:			
• Community living center	17	9	10
• Medicine	8	8	10
• Mental health <sup>1</sup>	2	–	–
• Neurology	–	1	2

<sup>1</sup> VHA medical facilities are classified according to a complexity model; a designation of “3” indicates a facility with “low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs.” “VHA Facility Complexity Model Fact Sheet,” VHA Office of Productivity, Efficiency & Staffing (OPES), October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census cont.: • Surgery	0	0	0

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, 2019, through September 30, 2020.

†October 1, 2020, through September 30, 2021.

‡October 1, 2021, through September 30, 2022.

§Unique employees involved in direct medical care (cost center 8200).

¶The Adult Inpatient Mental Health unit had been closed for renovation since April 27, 2020.

## Appendix C: VISN Director Comments

### Department of Veterans Affairs Memorandum

Date: September 20, 2023

From: Director, VA Northwest Health Network (10N20)

Subj: Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington

To: Director, Office of Healthcare Inspections (54CH06)

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

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington.
2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in the responses.

*(Original signed by:)*

Teresa D. Boyd, DO



## **Appendix D: Medical Center Director Comments**

### **Department of Veterans Affairs Memorandum**

Date: September 28, 2023

From: Director, Mann-Grandstaff VA Medical Center (668)

Subj: Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington

To: Director, VA Northwest Health Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington.
2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in responses to the draft report.

*(Original signed by:)*

Robert J. Fischer, MD

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
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<b>Inspection Team</b>	Kelley Brendler-Hall, MSN, RN, Team Leader Catherine McNeal-Jones, MSN, RN Judy Montano, MS Tamara White, BSN, RN
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<b>Other Contributors</b>	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Sonia Whig, MS, RDN Jarvis Yu, MS
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Director, Mann-Grandstaff VA Medical Center (668)

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