



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to assess allegations that senior leaders failed to practice high reliability organization (HRO) principles and created a culture of fear at the VA Eastern Colorado Health Care System (facility) in Aurora. Specifically, the identified senior leaders included the Facility Director, Chief of Staff (COS), deputy chief of staff for inpatient operations (DCOS-IO), and the associate chief of staff for education (ACOS-E). The OIG refers to these individuals as key senior leaders throughout the report.¹

Due to the breadth of the allegations received, the OIG initiated two separate, simultaneous healthcare inspections. While this inspection focused on whether key senior leaders' actions were contrary to HRO and just culture principles and led to widespread disenfranchisement of staff, the companion inspection focused on allegations related to the impact of facility leaders' actions on intensive care unit (ICU) provider coverage and patient care.

High Reliability Organizations and Culture of Safety

Per the Veterans Health Administration (VHA), "High reliability means evidence-based, exceptional care is consistently delivered for every patient, every time, at any facility across VHA."² VHA's HRO framework includes pillars, values, and principles.³ Leadership commitment is one of the HRO pillars and occurs when leaders reflect a commitment to safety and reliability in their decisions and actions.⁴

Culture of safety, another HRO pillar, refers to the importance of staff feeling safe to report concerns. Leaders build a culture of safety "by creating nurturing environments that build trust, respect and enthusiasm for improvement . . ." and demonstrate "that psychological safety exists, as evidenced by their words and deeds."⁵ A just culture recognizes staff members are more likely to report concerns, even their own errors, without fear of reprisal or punitive action. In a just

¹ Throughout the report, the OIG also uses the term *mid-level leadership* to describe positions below the COS position but above the service and section chief level, such as the deputy chief of staff for outpatient services, the DCOS-IO, the chief of medicine, and the intensive care unit director. The OIG notes that one key senior leader, the DCOS-IO, serves in a mid-level leadership position as described here.

² VA, Veterans Health Administration, "VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only," April 2023.

³ VHA, "High Reliability Organization (HRO) FAQ's," October, 2020. Throughout this report, the OIG often refers to HRO pillars, values, principles, and practices as the more general term, *HRO principles*.

⁴ VA, Veterans Health Administration (VHA), "VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only," April 2023.

⁵ VA, VHA, "Leader's Guide to Foundational High Reliability Organization (HRO) Practices, Pre-Decisional Deliberative Document - Internal VA Use Only," March 2022.

culture, trust exists between leaders and staff members and actions are judged fairly and “viewed first within the complexity of system factors.”⁶

Facility HRO Training and Milestones

Facility leaders and staff were familiar with HRO principles. As of June 2023, approximately 90 percent of supervisors and staff had completed HRO training. The Facility Director, who served as the facility’s HRO Champion, completed *HRO for executives* training in February 2020. The course included up to an eight-hour training and planning session focused “on the leadership behaviors, actions and resources needed to foster an HRO culture that empowers all staff members.”⁷ As of August 2023, four of seven members of the executive leadership team completed *HRO for executives* training, and as of October 2023, all executive leaders had completed baseline supervisory HRO training.

Inspection Results

Failure to Utilize HRO Principles Undermined a Culture of Safety

Although key senior leaders were trained in HRO principles, more than 50 current and former employees informed the OIG that key senior leaders failed to incorporate HRO principles into their practices, including the failure to establish and actively support a psychologically safe environment. The OIG found widespread disenfranchisement and a culture of fear contributed to poor organizational health and numerous clinical leader resignations.

Due to the widespread and troubling nature of these issues, OIG senior leaders met with VHA senior leaders on August 31, 2023, to share concerns regarding leadership and culture at the facility, as well as the losses of clinical leaders. In late September, VHA’s Central Office leaders conducted a review “to evaluate serious concerns shared by the OIG and VAMC [VA medical center] employees involving the culture of the medical center and substantial turnover of clinical leadership.” In late October 2023, the Veterans Integrated Service Network (VISN) Director made the decision to detail the Facility Director and COS away from their facility duties “to ensure a fair and transparent investigation into the multiple concerns” could take place.

⁶ VHA, “Why is Just Culture important to a High Reliability Organization (HRO)?” VHA Journey to High Reliability, <https://dvagov.sharepoint.com/sites/vhahrojournney/>. (This website is not publicly accessible.)

⁷ VA, VHA, “VHA High Reliability Organization (HRO) Glossary of Terms.” A facility HRO champion leads HRO work groups, communicates about HRO with facility staff, and ensures “oversight of HRO initiatives, outcomes, data, best practices and education activities within the facility;” VHA, “High Reliability Organization (HRO) FAQs.”

Creation and Impact of Culture of Fear

Through interviews and correspondence with current and former facility staff, the OIG substantiated that key senior leaders created an environment where a significant number of clinical and administrative leaders and frontline staff, from a multitude of service lines, felt psychologically unsafe, deeply disrespected, and dismissed, and feared that speaking up or offering a difference of opinion would result in reprisal.

Some facility staff reported experiencing moral distress or moral injury. Staff also expressed concerns about key senior leaders' disrespectful communications, including a physician and a facility leader who described the Facility Director's and COS' communication as "berating," or "demeaning" during townhall meetings. Another staff member shared a situation where the DCOS-IO "pointed their finger at the [physician] in front of 20 or however many people and said, 'I've heard about you.'" Staff also shared concerns and cited examples of key senior leaders failing to value the opinions and expertise of staff, making decisions "in haste," and dismissing concerns brought forward.

Facility staff shared fears of retaliation from key senior leaders. A staff member noted there were repercussions for sharing a different opinion, including being "berated in a meeting" or "pushed out" with false accusations in an investigation, while multiple staff shared concerns and expressed fears of being retaliated against and losing their jobs. A clinical leader described subtle forms of retaliation such as having staffing resources removed from the department. Another clinical leader described administrative investigations as being "weaponize[d]," with the intent of targeting individuals rather than finding the truth and making improvements.

When asked about actions taken to demonstrate psychological safety to staff, the Facility Director said, ". . . there's a lot of urban legends here that we're trying to conquer, but it's, . . . show me who's been fired. Show me who's been retaliated against." The Facility Director described regular efforts made to engage staff including rounding on units, holding quarterly townhall meetings and listening sessions, and attending and giving presentations at medical staff meetings. The Facility Director relayed concerns about staffs' resistance to change. Regarding psychological safety, the Facility Director said, "I don't know where the hysteria is coming from, but some people have really worked others up."

Lack of Psychological Safety in Peer Review Processes

The OIG substantiated that in January 2023, with the addition of the DCOS-IO and ACOS-E to the peer review committee (PRC), the culture of the PRC changed to an environment perceived by six clinical PRC members, as well as non-PRC service leaders and staff, to be psychologically

unsafe and punitive.⁸ Further, the OIG found that when learning of PRC members' concerns of psychological safety, key senior leaders missed opportunities to understand concerns and make efforts to foster a psychologically safe environment.

In January 2023, after the COS added the DCOS-IO and ACOS-E to the PRC, both key senior leaders began attending and acting as voting committee members.⁹ The majority of clinical PRC members interviewed reported the DCOS-IO and the ACOS-E took over or "dominated" committee discussions, and PRC meetings and processes became focused on finding fault and assigning blame as opposed to identifying patient care, practice, and process improvements. Some PRC members described feeling unsafe when attending committee meetings, with one member reporting feeling anxious and even nauseous. Several PRC members reported that physician groups, such as hospitalists and surgeons, were targeted by key senior leaders in peer reviews. Another PRC member shared that the fear of being peer reviewed led to a hesitancy to perform high risk procedures, while another described patient safety reporting as an avenue to assign blame.

Concerns regarding the PRC culture and the impact on providers were not limited to PRC members. Two former clinical service leaders expressed concerns about peer review such as "we're all afraid as doctors, I think there's no real psychological safety that people on the peer review will just go, for lack of a better phrase, go after us;" and another shared, "I have heard from four different services or sections from their representatives on peer review . . . that they've lost all faith in the peer review process since the arrival of the [DCOS-IO], the new Chief of Staff, and the [ACOS-E]."

When questioned by the OIG, the COS explained, ". . . we had new people in the peer review, and they started questioning the standard of care . . ." The COS stated that a change in culture was needed in PRC to assure all aspects of the standard of care were met in addition to ensuring impartial and vigorous discussions were taking place.

In July 2023, the COS and the DCOS-IO reported that the PRC meeting culture had improved, and members were comfortable giving feedback and participating in discussions. These opinions

⁸ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. VHA policy defines a peer review for quality management as "a critical review of care performed by a peer" to include "identification of learning opportunities for practice improvement and any related improvement actions recommended." The "process is to be consistent, timely, credible, comprehensive, useful, non-punitive, and balanced" fostering a responsive "environment where the clinician and clinical leadership can work together to address any opportunities for practice improvements and strong organizational performance." The Facility Director is responsible for the establishment of a PRC, designation of committee members (by position), and for ensuring "there is a credible process for assigning cases for peer review." The COS chairs the PRC and is responsible for clinical oversight. The numbers are representative of clinical provider members of the PRC but do not include COS, DCOS-IO, ACOS-E, or the Associate Director of Patient Care Services.

⁹ The OIG found that neither the DCOS-IO nor the ACOS-E were listed as voting members on the PRC Charter until July 2023, when the Facility Director updated and signed a new committee charter.

contradicted the experiences and perceptions shared with the OIG by many PRC members and leaders during the same time.

All Employee Survey Results Reflect Employees' Concerns

The OIG found the facility's 2023 All Employee Survey (AES) results reflected employees' concerns with effective and ethical leadership, organizational culture, and workplace satisfaction.¹⁰ The OIG noted the facility's results to be congruent with the sentiment clinical and administrative leaders and staff expressed regarding key senior leaders, professional and personal distress, and low morale and dissatisfaction.

Service and Section Leaders' Resignations and Vacancies

The OIG substantiated that mid-level leadership had been eroded and found leadership instability at the service level, with many clinical service and section-level resignations and extended vacancies. Further, numerous facility leaders left employment at the facility citing that a psychologically unsafe work environment was a major factor in their decision to leave employment.

Service and section leaders and staff reported concerns regarding the absence of permanent mid-level leaders in critical positions and a monopoly of control held by the three key senior leaders. One physician explained that "In a healthy leadership structure, a medicine chief would be able to advocate for the needs of patients and providers within the section. Instead, we do not have a safe and trusted supervisor, limiting checks and balances . . ." Another physician stated ". . . the interim chief of medicine [also the permanent DCOS-IO] . . . is clearly overworked with this additional position and is canceling the weekly section chief meetings frequently and on short notice. Essentially, there is no platform for us to discuss and solve issues."

The OIG verified two key senior leaders, relatively new to the facility, concurrently served in the acting role of mid-level managers.¹¹ The COS also functioned as the acting deputy chief of staff for outpatient operations from November 2022 through August 2023. The DCOS-IO dually served as the acting chief of medicine from January 2023 through the last update in October 2023. Furthermore, the ACOS-E assumed the role of the director of ICU in July 2023.

The OIG confirmed there were extended vacancies in several mid-level leadership positions and clinical service-line leadership positions. The chief of medicine position was vacated in September 2020 and as of October 2023 (three years later), hiring efforts remained in process. The section chief of hospital medicine position had been vacant since June of 2022. As of October 2023, the position was in active recruitment. Additionally, the chief of hematology and

¹⁰ The AES is a confidential, anonymous feedback tool distributed to federal employees annually to assess workforce satisfaction and organizational climate.

¹¹ The COS began facility employment in July 2022, and the DCOS-IO began facility employment in January 2023.

oncology resigned in July 2022, and the chief of care management and social work resigned in December 2022.

The OIG found a concerning pattern of clinical service and section chief resignations throughout 2023. From March through April of 2023, the section chief of cardiothoracic surgery, the deputy chief of anesthesiology, the deputy chief of mental health, and the deputy chief of surgery, resigned. In July 2023, the chief of physical medicine and rehabilitation resigned, and in October 2023, both the chief of anesthesiology and the chief of behavioral health resigned. Multiple staff and service leaders interviewed attributed the loss of clinical leaders to the actions and leadership style of the key senior leaders. The OIG found that despite these losses, the key senior leaders did not seek or utilize employee exit survey data to identify and address employee retention challenges.

Former Leaders' Reasons for Leaving Facility Employment

To understand the reasons leaders left facility employment, the OIG sent questionnaires to, and received responses from, 20 former facility leaders who left employment from 2021–2023.¹²

All former facility leaders reported that a lack of trust and confidence in senior leaders was an important factor in their decision to leave facility employment. Of the former facility leaders surveyed who reported that “poor or unsafe working conditions” was an important factor in the decision to leave facility employment, most provided narrative responses that described the unsafe working condition as being psychologically unsafe, such as perceiving the Facility Director “is a bully;” or “it felt to me like I was being bullied at times;” “there was an overall fear and distrust when it came to the [executive leadership team];” a “paranoid and fearful” culture; and a “toxic” environment.

The majority of the former facility leaders also reported that unethical behavior on the part of the leaders or the organization was an important factor in their decision to leave facility employment. Just under half of them reported harassment or retaliation for voicing concerns, and several reported harassment or retaliation for participating in a complaint process.¹³ All former facility leaders responded negatively when asked whether the executive leadership team’s culture and values aligned with their own. Further, former facility leaders were asked whether they felt executive leaders incorporated and practiced just culture. Most reported negative responses and cited examples including a fear of blame, culture of fear, failure to defer to expertise, and fear of

¹² Former facility leaders surveyed had served in positions such as clinical service chiefs and section chiefs and members of the executive leadership team. Most of the former leaders reported leaving employment in 2022 and 2023, and two former leaders reported leaving facility employment in 2021. The OIG utilized the VA employee exit survey questions, which incorporate HRO principles and values, to develop the former leaders’ questionnaire, and included open ended questions for respondents to provide additional information.

¹³ For the purposes of this report, unethical treatment factors included harassment or retaliation for voicing concerns, harassment, or retaliation for participating in a complaint process, and unethical behavior on the part of leadership or the organization.

retaliation. The majority of former facility leaders reported a negative response to the question, “. . . did you feel you could share patient or employee safety concerns and anticipate a fair and just response?”

Former facility leaders shared their perceptions of the key challenges at the facility. Almost all of the former facility leaders identified a leadership concern, such as fear of retaliation, feeling a disconnect existed between executive leadership and service chiefs, reporting service chiefs felt left “on an island with no upper-leadership support due to the blaming culture,” or a “toxic culture,” created by executive leaders, which made it difficult to recruit and retain staff. A little less than half of the former leaders’ responses described feeling undervalued or disrespected by senior leaders, and some reported experiencing medical concerns related to facility employment such as stress or mental health conditions, “a heart condition,” and in one case, a reported permanent disability.

The OIG concluded that the fears and concerns former facility leaders identified as key factors in their decision to leave facility employment echoed the reports and sentiment expressed by existing facility administrative and service-line leaders and frontline staff during OIG interviews. While there is new acting leadership at the facility, the OIG remains concerned about the ongoing departures of service and section chief leaders, the low morale of staff, and the potential current and future impact on patient safety and services.

Lack of VISN Leaders’ Oversight

In an OIG interview in May 2023, a week prior to his retirement, the VISN Chief Medical Officer explained having responsibility for the oversight of clinical operations across the VISN. When asked about the number of service chief departures and extended vacancies at the facility, the Chief Medical Officer reported being “peripherally aware” of and concerned about the issue but denied having knowledge about recruitment efforts.

The OIG team interviewed the newly appointed VISN Director in July 2023, who reported serving as the Interim VISN Director from December 31, 2022, until permanently appointed on June 4, 2023.¹⁴ The VISN Director shared having heard concerns about the Facility Director’s leadership style creating a negative environment; however, the VISN Director reported the belief that the Facility Director was making efforts to improve the culture at the facility, although these efforts may have been hampered by actions taken by the Facility Director and the COS to hold employees accountable. As the interview progressed, the VISN Director noted the difficulty of not having a Chief Medical Officer at the VISN and acknowledged the need for her clinical team to increase their oversight and reporting of facility-level concerns.¹⁵

¹⁴ Previously, the VISN Director reported serving as the VISN’s Deputy Network Director and was responsible for the oversight of administrative operations across the VISN.

¹⁵ At the time of the interview, the VISN Director reported the VISN Chief Medical Officer position was vacant.

The turnover in VISN leadership positions and subsequent vacancy of the Chief Medical Officer, as well as ineffective communication, contributed to the VISN Director's lack of awareness regarding the extent of the clinical staffing and culture challenges at the facility.

The OIG made two recommendations to The Under Secretary for Health related to reviewing VISN leaders' awareness and oversight of facility operations, staffing, and leaders' adherence to HRO principles, and utilizing the review to standardize VISN practices and oversight activities.

The OIG made four recommendations to the VISN Director related to reviewing key senior leaders' actions and adherence to HRO principles, developing and implementing an avenue for facility employee feedback, providing oversight of the Facility Director's efforts toward resolving clinical service leader vacancies, and ensuring access to employee exit and transfer surveys.

The OIG made one recommendation to the Facility Director related to the utilization of employee exit surveys to identify challenges with employee retention.

VA Comments and OIG Response

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with the recommendation(s) and provided an acceptable action plan (see appendixes B, C, and D). The OIG considers all recommendations open pending documented evidence for closure. The OIG will follow up on the planned actions until they are completed.



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Abbreviations

ACOS-E	associate chief of staff for education
AES	all employee survey
AIB	administrative investigation board
COS	Chief of Staff
DCOS-IO	deputy chief of staff for inpatient operations
DCOS-OO	deputy chief of staff for outpatient operations
HRO	high reliability organization
ICU	intensive care unit
OIG	Office of Inspector General
OHI	organizational health index
PRC	peer review committee
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted an inspection to assess allegations that senior leaders failed to practice high reliability organization (HRO) principles and created a culture of fear, which impacted staffing and clinical services at the VA Eastern Colorado Health Care System (facility) in Aurora.¹ Specifically, the leaders identified in the allegations included the Facility Director, Chief of Staff (COS), deputy chief of staff for inpatient operations (DCOS-IO), and the associate chief of staff for education (ACOS-E); the OIG refers to these leaders as key senior leaders throughout this report.²

Due to the breadth of the allegations and the reported impact on a multitude of clinical processes and services, the OIG initiated two separate but simultaneous healthcare inspections. While this inspection primarily focused on leadership and HRO principles, the companion inspection focused on allegations related to the impact of facility leaders' actions on intensive care unit (ICU) provider coverage and patient care.

Background

The facility, part of Veterans Integrated Service Network (VISN) 19, consists of the Rocky Mountain Regional VA Medical Center located in Aurora, Colorado, and seven community-based outpatient clinics throughout Colorado. The facility is a level 1a, highest complexity facility offering an array of healthcare services, such as primary and mental health care, as well as specialized services, including cardiovascular and thoracic surgery.³ From October 1, 2022, through September 30, 2023, the facility served 101,411 patients. The facility has multiple academic affiliations including the University of Colorado School of Medicine and trains over “120 residents, 450 medical students, and 370 nursing students” every year.⁴

¹ Although the Veterans Health Administration defines and differentiates between HRO pillars, values, and principles, this report often uses the general term *HRO principles* when discussing these terms and practices.

² Throughout the report, the OIG also uses the term *mid-level leadership* to describe positions below the COS position but above the service and section chief level, such as the deputy chief of staff for outpatient services, the DCOS-IO, the chief of medicine, and the intensive care unit director. The OIG notes that one key senior leader, the DCOS-IO, serves in a mid-level leadership position as defined here.

³ VHA Office of Productivity, Efficiency and Staffing, “Facility Complexity Model Fact Sheet,” January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex; Level 3 facilities are considered the least complex; VA Eastern Colorado Health care, “Health Services,” accessed September 5, 2023, <https://www.va.gov/eastern-colorado-health-care/health-services/>.

⁴ “About Us,” VA Eastern Colorado Health Care, accessed April, 26, 2023, <https://www.va.gov/eastern-colorado-health-care/about-us/>.

Allegations and Related Concerns

The OIG received allegations that key senior leaders' actions were contrary to HRO and just culture principles and led to widespread disenfranchisement of staff and the "establishment of a culture of fear and retaliation." Allegedly these actions led to negative impacts on clinical programs and staff morale:

- The facility's peer review committee (PRC), reorganized in January 2023, was used by key senior leaders to target a group of physicians and had become psychologically unsafe and punitive.
- Mid-level leadership had been eroded through numerous resignations and forced removals leading to multiple service and section chief vacancies.

During the course of the inspection, the OIG identified additional concerns related to employee exit and transfer surveys.

Scope and Methodology

The OIG initiated the inspection on May 1, 2023, and conducted joint site visits June 20–23, July 13 and 18, 2023.⁵ The OIG conducted approximately 60 interviews with the final interview conducted on January 23, 2024.⁶ The OIG interviewed and corresponded with former and current VISN 19 and facility leaders; clinical service and section chiefs, and administrative leaders; quality, safety, and value leaders; physicians, and other clinical and administrative staff from a multitude of service lines.⁷

The OIG reviewed relevant VA, Veterans Health Administration (VHA), and facility policies and guidelines. The review also included facility administrative reviews, peer reviews, committee charters, agendas and minutes, All Employee Survey (AES) results, and staffing documents.

⁵ For the purpose of this report, a joint site visit refers to a companion OIG team who performed site visits and conducted interviews simultaneously.

⁶ These interviews include those conducted by this OIG team, and by the OIG team conducting the companion report, VA OIG, *Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora*, Report No. 23-02179-189, June 24, 2024.

⁷ Some of the individuals listed were both interviewed by and corresponded with the OIG; others were either interviewed by or corresponded with the OIG.

The OIG disseminated a questionnaire to 20 former facility leaders who voluntarily left facility employment from 2021 through 2023 to understand their reasons for leaving the facility; the OIG received and evaluated responses from all 20 former facility leaders.⁸

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

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

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

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

Inspection Results

Failure to Utilize HRO Principles Undermined Culture of Safety

During the inspection, facility staff informed the OIG that key senior leaders were trained in HRO principles. However, the OIG heard multiple reports of key senior leaders failing to incorporate HRO principles into their practices, including the failure to establish and actively support a psychologically safe environment, which impacted multiple clinical processes and services. The OIG found widespread disenfranchisement and a culture of fear contributed to poor organizational health and numerous resignations by clinical leaders.

Due to the widespread and troubling nature of the issues brought forward, OIG senior leaders met with VHA senior leaders on August 31, 2023, to share concerns regarding the leadership and culture at the facility, as well as the losses of service-line leaders. Through correspondence with

⁸ The OIG used VA exit survey questions, and HRO materials to develop questions. The team sent information requests to 20 former executive leaders, service, and section chiefs who were not employed at the facility, or the VISN at the time the survey was disseminated.

the VISN Director, the OIG learned that in late September, leaders from VHA’s Central Office conducted a review “to evaluate serious concerns shared by the OIG and VAMC [VA medical center] employees involving the culture of the medical center and substantial turnover of clinical leadership.” In late October 2023, the VISN Director made the decision to detail the Facility Director and COS away from their duties at the facility “to ensure a fair and transparent investigation into the multiple concerns” could take place.

High Reliability Organizations and Culture of Safety

VHA began implementing HRO practices as early as the 1990s and began planning for an HRO enterprise-wide implementation in 2018, which was incorporated into VHA’s Long Range Plan in 2022. “High reliability means evidence-based, exceptional care is consistently delivered for every patient, every time, at any facility across VHA.”⁹ VHA’s HRO framework includes HRO pillars, values, and principles (HRO principles).¹⁰ VHA guidance states that harm can be avoided by becoming proficient in the three HRO pillars.¹¹ Leadership commitment is one of the HRO pillars and occurs when leaders reflect a commitment to safety and reliability in their decisions and actions. Another HRO pillar, continuous process improvement, occurs when all staff members engage in improvement activities, and use tools for continuous learning and improvement.¹²

Culture of safety, the third HRO pillar, refers to the importance of staff feeling safe to report safety concerns because they trust leaders will communicate openly about meaningful improvements to prevent harm and learn from mistakes.¹³ Leaders build a culture of safety “by creating nurturing environments that build trust, respect and enthusiasm for improvement . . .” “Leaders must create frequent ‘moments of truth’ demonstrating that psychological safety exists, as evidenced by their words and deeds.”¹⁴ According to research, leaders have a key role in

⁹ VA, Veterans Health Administration, “VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only,” April 2023.

¹⁰ VHA, “High Reliability Organization (HRO) FAQs,” October 2020.

¹¹ VHA, “High Reliability Organization (HRO) FAQs.”

¹² VA, Veterans Health Administration, “VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only.”

¹³ VA, Veterans Health Administration, “VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only.”

¹⁴ VA, VHA, “Leader’s Guide to Foundational High Reliability Organization (HRO) Practices, Pre-Decisional Deliberative Document - Internal VA Use Only,” March 2022; VA, VHA, “VHA High Reliability Organization (HRO) Glossary of Terms,” May 2023. The other HRO components include, leadership skills, leadership activities, teamwork, communication, accountability, alignment, reliability, improvement and measurement, and continuous learning.

fostering psychological safety, which occurs when staff caring for patients feel safe and empowered to raise concerns or offer suggestions for improvement.¹⁵

According to the VHA National Center for Patient Safety, “the term safety culture describes the contexts in which patient care is delivered as well as the shared values, attitudes and behaviors that determine how organizational members minimize patient harm during the delivery of care.” Further, “Top leaders must also craft a reporting relationship that ensures safety officers deliver unfiltered information to key decision makers in the organization.”¹⁶ A just culture recognizes that staff members are more likely to report concerns, even their own errors, without fear of reprisals or punitive actions. In a just culture, trust exists between leaders and staff members and actions are judged fairly and “viewed first within the complexity of system factors.”¹⁷

Respect for people, an HRO value, involves ensuring that people feel comfortable sharing information to improve patient care.¹⁸ A VHA fact sheet communicates key messages regarding respecting people:

- Creating an environment of trust; ensuring staff, patients, and caregivers feel valued and empowered
- Respecting coworkers and patients, to ensure people feel respected and valued and share information to partner with ensuring safe care
- Fostering a culture of respect that improves “joy in work”
- Respecting others to receive respect in return, and taking pride and satisfaction in work
- Ensuring awareness that performance improves when people feel valued, “making a difference for our Veterans and for each other”¹⁹

There are five HRO principles, which provide a “foundation for HRO initiatives and activities,” (see table 1).²⁰

¹⁵ John S. Murray, Sarah Kelly, Christine Hanover, “Promoting Psychological Safety in Healthcare Organizations,” *Military Medicine*, Volume 187, Issue 7-8, July-August 2022, pp. 808–810, <https://academic.oup.com/milmed/article/187/7-8/808/6542956>.

¹⁶ VHA, “National Center for Patient Safety; NCPS Approach to Achieving High Reliability,” accessed September 19, 2023, https://www.patientsafety.va.gov/features/NCPS_APPROACH_TO_ACHIEVING_HIGH_RELIABILITY.asp.

¹⁷ VHA, “Why is Just Culture important to a High Reliability Organization (HRO)?” VHA Journey to High Reliability, <https://dvagov.sharepoint.com/sites/vhahrojourney/>. (This website is not publicly accessible.)

¹⁸ VA, VHA, “VHA High Reliability Organization (HRO) Glossary of Terms.”

¹⁹ VHA, “HRO Value: Respect for People Fact Sheet.”

²⁰ VA, VHA, “VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only;” VA, VHA, “VHA High Reliability Organization (HRO) Glossary of Terms,” May 2023.

• **Table 1. HRO Principles**

HRO Principle	VA Definition of HRO Principle
Sensitivity to operations	“Be mindful of people, processes and systems that impact patient care.”
Preoccupation with failure	“Have a laser-sharp focus on catching errors before they happen and predicting and eliminating risks before they cause harm.”
Reluctance to simply	“Get to the root causes of a problem rather than settling for simple explanations.”
Commitment to resilience	“Bounce back from mistakes, get back on track and prevent those mistakes from happening again.”
Deference to expertise	“Empower and value expertise and diversity of perspectives and insights. Rely on those with the most knowledge of a situation at hand, regardless of rank, hierarchy, position or other factors.”

Source: VA, VHA, “VHA High Reliability Organization (HRO) Glossary of Terms,” May 2023.

Facility HRO Training and Milestones

In correspondence, the facility’s high reliability officer and the chief of quality, safety, and value, informed the OIG of the following HRO trainings and assessment milestones reporting as of

- February 2020, the Facility Director, who was the facility’s HRO Champion, completed HRO for executives training.²¹
- September 2021, a VHA HRO support team conducted a facility HRO assessment and in response, the facility developed a “detailed site-specific HRO Implementation Plan” in October 2021.²²
- June 2023, approximately 90 percent of facility supervisors and employees had completed HRO baseline training.
- August 2023, four of seven members of the executive leadership team completed HRO for executives training.

²¹ VA, VHA, “VHA High Reliability Organization (HRO) Glossary of Terms.” A facility HRO champion leads HRO work groups, communicates about HRO with facility staff, and ensures, “oversight of HRO initiatives, outcomes, data, best practices and education activities within the facility.” VHA, “High Reliability Organization (HRO) FAQs, October 2020. HRO training for executive leaders included up to an eight-hour training and planning session focused “on the leadership behaviors, actions and resources needed to foster an HRO culture that empowers all staff members.”

²² The HRO Implementation plan was developed collaboratively with the facility executive leadership team, VISN and facility HRO leaders, and the VHA HRO Support team.

- October 2023, all members of the executive leadership team completed HRO baseline training for supervisors.²³

Creation and Impact of Culture of Fear

The OIG substantiated that key senior leaders failed to utilize HRO principles, undermined the stability and psychological safety of service leaders and staff, and created a culture of fear. The OIG found that key senior leaders created an environment where a significant number of clinical and administrative leaders and frontline staff, from a multitude of service lines, felt psychologically unsafe, deeply disrespected, and dismissed, and feared that speaking up or offering a difference of opinion would result in reprisal. Further, numerous facility leaders left employment at the facility citing that a psychologically unsafe work environment was a major factor in their decision to leave employment.

Culture of Fear

During the inspection, the OIG found key senior leaders' widespread disenfranchisement of clinical and administrative leaders and frontline staff and a culture of fear. During interviews and through written correspondence, more than 50 staff members, including many former and current facility section chiefs and service chiefs, expressed concerns related to senior leaders' failure to enact HRO values and principles.

The following excerpts from interviews highlight the fears.

- “We would be afraid to bring things up because [we] didn't know if we would get kind of . . . slapped in the face or told to stand down or that wasn't worth bringing up. But it would be important to us, but it seemed like it wasn't important to anybody else.”
- “And so [the physicians] pretty quickly moved to saying gosh, if a mistake happens, we're going to be blamed as opposed to engage in a quality and safety culture. . . . It went from a culture of safety to a culture of blame. . . . So I feel confident saying this that somebody spoke up very early on in the process and said we don't think that this is safe . . . and [the DCOS-IO] pointed [their] finger at the [physician] in front of 20 or however many people and said, 'I've heard about you,' was the response. And so, I think that had a very chilling effect and sort of set the tone for people.”
- “Most disheartening is the three [to] four instances, probably more, that I've reached out that have then been escalated to the Chief of Staff. It has not been my

²³ The facility high reliability officer reported understanding that HRO baseline training for supervisors satisfied the requirement for HRO baseline training for executives.

impression that they're interested in making wholesale changes to improve these problems that they've created. Instead, what ends up happening is they end up blaming our learners . . . I feel very unsupported by our Chief of Staff. I feel very supported by my group . . . But that's what's so terrible about that. You feel just kind of hopeless about the whole thing. How many of these events do we need to have? . . . Nothing's changed. In fact, the changes we make get worse."

Many staff referenced concerns, either during interviews or by correspondence, about the communication style of key senior leaders. In an interview, a physician expressed concern regarding the communication by the Facility Director and COS described as "berating," during a 2023 townhall meeting and said,

So, there's whispers going around that people were dissatisfied working here and so the director and company sent out an invitation at 1:00 p.m. on a Tuesday and said we're hosting a town hall meeting today at 5:00 p.m. That was the notification—four hours. Everybody showed—standing room only. That's how upset everybody was. . . . It was pretty much every service and section chief that still has a job here was there, along with providers for those different services, and it started off with [the COS and Facility Director] just berating us for going outside of the hierarchy. . . . So, what was ostensibly a town hall meeting was just them grilling us for reaching outside of our chain of command.

In written correspondence, a facility leader referenced similar concerns with the Facility Director's communication saying, "During public townhall meetings, the responses by the Director to concerns from staff have been at best demeaning."

Through interviews or correspondence, multiple staff reported experiencing moral distress or injury. Two mental health providers who voiced concerns about the executive leadership team related to moral distress or moral injury are included below.²⁴ A psychologist reported,

Our current executive management . . . is tightly focused on compliance and takes a punitive approach. There is no interest in or respect for clinician voices. There

²⁴ Andrew Jameton, "What Moral Distress in Nursing History Could Suggest about the Future of Health Care." *AMA Journal of Ethics* 19, no. 6 (June 2017): 617-28. <https://doi.org/10.1001/journalofethics.2017.19.6.mhst1-1706>. Moral distress refers to the "experience of knowing the right thing to do while being in a situation in which it is nearly impossible to do it."; VA, PTSD: National Center for PTSD, "Moral Injury," accessed December 7, 2023, https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp. "Moral injury is the distressing psychological, behavioral, social, and sometimes spiritual aftermath of exposure," to events that "contradict deeply held moral beliefs and expectations." "Individuals may also experience betrayal from leadership, others in positions of power or peers that can result in adverse outcomes." . . . 'Moral injury can occur in response to acting or witnessing behaviors that go against an individual's values and moral beliefs.' 'In order for moral injury to occur, the individual must feel like a transgression occurred and that they or someone else crossed a line with respect to their moral beliefs.'

have been significant changes made in organizational structure and the way clinicians' time is booked, with no clear explanation from management about why these changes are important. While there is something a vague reference to HRO principles, there is never any case made for how these changes are connected to excellent veteran care and, in fact, many staff feel that these organizational changes keep us from caring for Veterans the way we were trained. The resulting moral distress has led to an exodus of skilled staff at all levels, which in turn harms veteran care. . . . Moral Injury: . . . 'doing our best and then over and over being told we are never actually doing enough.' . . . When . . . concerns are voiced, . . . get told 'well, we're all here for the Veterans, so if you're not here for the Veterans and you just want . . . then maybe you shouldn't be here . . .'

A social worker described contributors to the "problem":

[The Facility] Director and his [executive leadership team] colleagues have created and fostered a culture of fear here and many of us have no confidence in their leadership/management of this institution. I have a wonderful position here, but I have begun to consider leaving my position due to their failure. There is a pervasive problem here with lack of transparency/extremely poor communication, snap decisions made with little planning, concerns regarding patient safety, severe moral distress among providers and an overall culture of fear.

The chief, quality, safety, and value shared a July 2023 update reporting leaders' commitment to providing consistent messaging at all levels on HRO and improvements to employ a just culture focused on patient safety. While the facility's July 2023 HRO update reported that improvements were made to increase joy in the workplace, the OIG found that many former and current facility leaders and staff reported widespread fear, lack of psychological safety, and fear of retaliation. Excerpts from interviews and written correspondence with current and former facility leaders and a physician provide examples of these reports.

- "I mean, it's to the point of conspiracy level, fear of the . . . power to perform retaliations just because so many people hear these stories of, and we have so many examples of people being blackballed and they themselves submitted OIGs with no protection. So as you hear stories hear through that lens, people are scared."
- "I do think there are opportunities to have a culture of accountability, but accountability doesn't look like a big stick, right? And so I think that you know, sometimes, we mask accountability to be something that it's not. And I wouldn't say that we're like building a culture of accountability here. I think it's probably a culture of what I've noticed is a culture of fear, a culture of blame, and using the stick to punish people."

- “I’m scared of [the Director], basically, I do not feel psychologically safe around him, and I haven’t for years . . . I still need him for any career advancement, I don’t want to ruin my career because that’s a lot of the fears that I don’t want to speak for other people, but that’s sort of the culture and the fear here is that he, you cross him, you’re in trouble if you get on his bad side, you are in trouble. And I was already on his bad side . . . He values loyalty above anything else.”
- “I fear for retaliation. And you know there are rules against that. . . . They’re not going to put me in a basement office without a window. That’s not their retaliation. But reassigning the nurse that works in our department somewhere else, you know? Well, that’s just a management decision. Can’t prove that, so no, I have I hesitated a long time before I contacted [the OIG].”
- “I don’t think on any level [the Facility Director] creates a culture of safety. Everything is done from a very punitive and fear tactics you are not encouraged to have opinions. And if your opinion differs, there are clear repercussions that can be anything from being berated in a meeting to being pushed out on the back end with some false accusations or claims that then have to be investigated and people are removed from positions. There is no culture of safety. There is no deference to expertise. There is no embodiment of the HRO principles. It is very much so a fear mongering culture.”

Several providers shared examples of when their expertise was not valued and reported their concerns related to a process change proposed by the COS to the facility’s Out of Operating Room Airway Management (OOORAM) program were dismissed.²⁵

- “I’ve voiced my concern about being able to [make a major operational change] within three days of [the] request. And I was told quote by the Chief of Staff, your Chief of Staff has given you an order and you will comply. There was no deference to subject matter experts, of which there were five on this call, and it was very obvious that the decision had been made prior to the meeting and that the meeting was a way to convey the expectation within a kind of unreasonable time period of 72 hours.”²⁶
- “The subject matter experts . . . said everything was done correctly. I don’t understand what the issue is and then it was no, we now need OOORAM [Out of

²⁵ VHA Directive 1157(1), *Out of Operating Room Airway Management*, June 14, 2018, amended September 19, 2018. OOORAM refers to the specific training, skills, and competency of providers in performing emergent airway management in clinical areas outside of facility operating rooms.

²⁶ During an interview with the COS, the OIG learned the proposed process change to the facility’s OOORAM program was not enacted.

Operating Room Airway Management] Level 3 all times in the hospital, which is not what the directive says.” “When it all got finally done, nothing. It’s being done exactly the same now as it was that nine months, ten months ago, when that all happened. It was like, it was a very much, a knee jerk reaction in the moment that without understanding everything and not letting the subject matter experts actually explain . . . caused a lot of heartache for three people.”

Similarly, the OIG reviewed internal email correspondence in which multiple providers voiced concerns regarding changes, made abruptly, by the DCOS-IO to the process of admitting patients from the emergency room to the inpatient unit without adequate planning, communication, or stakeholder engagement.

- “This is an example of a decision made in haste without consideration of repercussions from the perspective of resident involvement or actual implementation, a case-in-point of concerns raised at the clinical staff townhall yesterday.
- “Implicit in this change is that we are not worthy to make the decision. . . .Of course I don’t think it matters that much what my opinion is, but I don’t think that I could go without speaking my mind.”
- We have all received the numerous emails from providers regarding their concerns with the new ED [emergency department] admission process . . . Several [providers] are invoking “Stop the Line” language in their personal communications with me . . . I believe there are some valid concerns with the sudden change in a long-standing process that could have patient safety implications. My instinct is to pause on this rollout until we can get people in a room to discuss further. However, I don’t think that is my decision to make. Would like your guidance on this. [This is an excerpt of an email sent from a former leader to the DCOS-IO.]²⁷
- When asked about actions taken individually and by leaders to demonstrate psychological safety to facility staff, the Facility Director said,

. . . there’s a lot of urban legends here that we’re trying to conquer, but it’s . . . , show me who’s been fired. Show me who’s been retaliated against. I personally demonstrated by my own rounding I go out on the units, and I round, and I talk to staff, and I listen to staff. I have quarterly town halls. Every month I have some kind of all-staff type of event where I can in once a quarter. I even have a listening session where a facilitator asks questions and asks for their input. . . and

²⁷ When questioned by the OIG if Emergency Department providers had given feedback on the process changes, the DCOS-IO stated that despite seeking feedback, no concerns were reported. The DCOS-IO added that the former acting chief of hospital medicine informed the DCOS-IO there had been no complaints.

I attend the all-medical staff meeting and give a presentation there . . . I've looked for those key leaders to that might not be a formal leader, but informal leader, and have . . . gone for walks with them around the hospital just to hear their input . . . I think it's there, but I think the resistance to change is greater . . . I don't know where the hysteria is coming from, but some people have really worked others up.

The OIG found, despite many former and current facility leaders and staff reporting lack of psychological safety and fear of retaliation in the workplace surrounding senior leadership, the Facility Director dismissed employees fears as “hysteria” caused by the influence of “some people.”

The OIG also received reports that staff feared various facility investigations. One facility leader and a former facility leader described the basis for the fear.

- “And I think that in the current environment because of what is kind of going on in terms of being relieved of positions and people . . . are in fear of their jobs and that they may make choices that are not in the best interest of those patients, even though they have some risk and risk to the individuals for those decisions. . . . I think . . . the environment . . . is putting some people at risk.”
- “But I can tell you these . . . things, that this institution, investigations, the word I would use is weaponize, but they're used against people and investigations should be to find the truth. And to make the place better, right?”

The OIG learned the Facility Director chartered an Administrative Investigative Board (AIB) on April 18, 2023, unrelated to the scope of this OIG inspection. The OIG reviewed the AIB findings, dated August 17, 2023, and noted the AIB identified a supplemental finding related to witnesses expressing “fear of retaliation or low morale.”²⁸ The AIB indicated that reasons for this finding were witnesses who reported that they

- felt unsafe or reported others felt unsafe,
- perceived investigations were weaponized or targeted toward specific people,
- feared retaliation from service chiefs and the executive leadership team, or
- planned to step down from their positions or leave the VA.

The AIB recommended the facility “consult with VA sponsored support programs for assistance with building trust and productive relationships with leadership and clinical staff,” citing that “evidence of trust and relationship gaps were found in clinical services with relation to executive leadership team . . .” Although the issues prompting the AIB were outside the scope of the

²⁸ VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021. An AIB is an administrative investigation to collect and analyze evidence, facts, and information on matters of interest to VA.

OIG’s inspection, the sentiment and fear expressed by facility staff and leaders interviewed during the AIB investigation echoed concerns employees reported to the OIG.

Lack of Psychological Safety in Peer Review Processes

The OIG substantiated that in January 2023, with the addition of the DCOS-IO and ACOS-E to the committee, the culture of the PRC changed to an environment perceived by six clinical PRC members, as well as non-PRC service leaders and staff, to be psychologically unsafe and punitive.²⁹ The OIG was unable to determine whether key senior leaders used PRC processes to target a physician group.

VHA policy defines a peer review for quality management as “a critical review of care performed by a peer” to include “identification of learning opportunities for practice improvement and any related improvement actions recommended.”³⁰ The primary focus of peer review is to determine whether the “clinical decisions and actions of a clinician during a specific clinical encounter met the standard of care.”³¹ The “process is to be consistent, timely, credible, comprehensive, useful, non-punitive, and balanced” fostering a responsive “environment where the clinician and clinical leadership can work together to address any opportunities for practice improvement and strong organizational performance.”³²

A culture of safety, as described previously in this report, is the establishment and sustainment of just culture, and an atmosphere of trust.³³ In a just culture, staff feel safe reporting concerns and trust that actions are going to be “judged fairly.”³⁴

The Facility Director has responsibility for peer reviews for quality management and is responsible for ensuring the establishment of a PRC, the designation of committee members (by position), and for ensuring “there is a credible process for assigning cases for peer review.” The COS chairs the PRC and is responsible for clinical oversight.³⁵ The PRC Charter outlines the composition and designation, by position, of voting members.³⁶

²⁹ The numbers are representative of clinical provider members of the PRC and do not include senior leaders such as the COS, DCOS-IO, ACOS-E, or the Associate Director of Patient Care Services. The OIG did not interview all of the PRC members.

³⁰ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

³¹ VHA Directive 1190. Standard of care refers to a specific protocol that guides the care provided to diagnose and/or treat a patient’s condition, or clinical circumstance. The standard of care is met if comparable clinicians who encountered the same situation would have handled it similarly.

³² VHA Directive 1190.

³³ VHA, “HRO Just Culture Fact Sheet”; VHA, *High Reliability Organization Glossary*.

³⁴ VHA, “HRO Just Culture Fact Sheet.”

³⁵ VHA Directive 1190.

³⁶ Eastern Colorado Health Care System, *Peer Review Committee Charter*, November 26, 2021.

During interviews and a review of PRC meeting minutes, the OIG learned that in January 2023 two key senior leaders, the DCOS-IO and the ACOS-E, began attending committee meetings as PRC voting members.³⁷ The OIG reviewed the PRC charter and found the charter did not designate either the DCOS-IO or the ACOS-E position as a PRC member. Further PRC meeting minutes revealed that prior to January 2023, these positions were listed as “Ad-Hoc/Non-Voting Members/Guests.”

The OIG questioned the COS about the PRC charter and designated committee membership. The COS acknowledged the committee charter may not be updated but reported using committee designation letters to add members to various committees and recalled signing one for the ACOS-E but did not confirm signing a designation letter for the DCOS-IO. The COS explained reviewing committee memberships to ensure the right individuals were on the committee and had planned to update charters to include service chiefs versus frontline staff as PRC members.

In an interview with the OIG, the chief of quality, safety, and value told the OIG that historically the charter was always updated when new members were added and that it took some time to get the charter approved and signed by the Facility Director. The chief of quality, safety, value further reported that normally new members attend as guests and are not permitted to vote until the committee charter is updated and could not explain why that practice was not followed in this case.

The OIG concluded that the COS, who chairs the PRC, assigned and permitted the DCOS-IO and ACOS-E to actively participate as members of the PRC and vote on peer review levels without either position being listed as *voting member* on the PRC charter. This practice continued from January through July 2023 when the Facility Director, responsible for the composition of the PRC, signed a new charter designating both positions as voting PRC members.

The OIG conducted interviews with PRC members, clinicians, and clinical service and section chiefs to understand whether their experiences with peer review processes were in alignment with VHA’s policy of the process being credible, non-punitive, and balanced, and fostered a responsive environment where clinicians and clinical leaders work together.³⁸

The majority of the clinical PRC members interviewed shared perceptions that in January 2023, after the COS added the DCOS-IO and ACOS-E to the committee, the PRC culture became

³⁷ At that time, the ACOS-E and the DCOS-IO were new to the facility. Per VISN human resources officers, the ACOS-E and the DCOS-IO began employment at the facility in December 2022 and January 2023, respectively.

³⁸ VHA Directive 1190.

unsafe and punitive in nature; PRC meetings and processes became focused on finding fault and assigning blame as opposed to identifying patient care, practice, and process improvements.³⁹

A clinical PRC member stated that the DCOS-IO and the ACOS-E “dominated” the PRC meeting discussions. The PRC member added the focus of peer review had become finding fault without consideration of process concerns and said,

I would say that it’s my view and the view of multiple other members of the board that the focus of peer review has turned to blaming clinicians, and at times doing so, with disregard to system issues that have set clinicians up for failure.

A second clinical PRC member shared that the peer review process was no longer focused on identifying system problems or educating clinicians and added that “[the DCOS-IO and ACOS-E] are by far the most vocal people in that meeting now.” The PRC member also stated,

. . . it feels like more we’re defending our providers instead of explaining facts and identifying like the actual issues around the care . . . it’s just like we get this feeling of like anxiety and nausea going into this meeting because it’s so punitive.

A third clinical PRC member stated, “. . . I felt like peer review was . . . no longer a safe place to like review patient . . . events.” The PRC member explained “. . . over the last few months peer review has felt more like a witch hunt and not with the intent of providing feedback to improve patient care.” The PRC member added that there was a sense of hospitalists being targeted and not treated equally, stating,

. . . there were exceptions and assumptions . . . made for ICU providers that weren’t made for [hospitalists]. That it really felt like it was meant, it felt like the intention from my perspective, was to justify removing [hospitalists] from being involved in the care of patients who are critically ill.⁴⁰

A fourth clinical PRC member said, “Peer review is supposed to be non-pejorative, but I think there’s a sense in the provider group that it is being used in a pejorative way to try to get things

³⁹ Three additional clinical PRC members interviewed acknowledged changes in PRC meetings following the addition of the two key senior leaders but did not describe the tone or culture as hostile. One member reported the meeting as “. . . collegial [with] a bit more vigorous debate” and another member described the discussions as “robust” and “professional.” A third member provided a conflicted account, stating that the meetings were “collegial” and “professional,” but later reported that (the member) is “super tolerant . . . you can say a lot of really confrontational things to me . . .” adding “People do not like it because nobody wants to feel stupid.”

⁴⁰ A companion OIG report, *Extended Pause in Cardiac Surgeries and Leaders’ Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora*, provides further detail about the facility leaders decision related to hospitalists care of critically ill patients.

to happen.”⁴¹ The PRC member added, “You know, framing it as a provider issue as opposed to a systems issue.” “People get scared when they get a letter that says you’re being reviewed . . .” The PRC member further reported that the fear of being peer reviewed had caused surgeons to avoid performing high risk procedures, stating

There have been a rash of surgical cases that have been reviewed by peer review that . . . led to a hesitancy for our surgeons to operate here on high level acuity cases. So that slows the surgical ICU down. And so that’s something that I have seen firsthand is kind of avoiding higher acuity cases . . .

A fifth clinical PRC member reported previously enjoying peer review and the learning opportunities as a member, however, reported after the addition of the DCOS-IO and ACOS-E the culture changed. The PRC member shared that, “People actually tried to get off of peer review because of how toxic it felt on there.” The PRC member added it was “the two, the [ACOS-E] and [DCOS-IO], were the ones that kind of took over the whole thing . . .” and because “they dominated, sometimes it was not understood that what they are saying isn’t correct.”

Further, the PRC member shared a concern that the chief of surgery was targeted in peer review and was repeatedly brought forward to PRC for “little things,” stating

Peer reviews [are] never supposed to be that way. But I felt they were. They tried to go after a person administratively, and now they were going after [the chief of surgery] in a different way, is how it felt. Umm yeah, it, it definitely culture shifted.

A member of staff who reported being a former PRC member described a culture of blame in patient safety reporting as well as peer review and told the OIG

It basically now feels like the point of a patient safety report is to figure out who’s to blame for those things, and that is a change. I’ll say the same about the peer review culture . . . prior to the changes in leadership, that was honestly one of the best run committees Thought to identify system things and also provide meaningful feedback to providers and in the past six months this has felt targeted and no longer safe at all.

The OIG learned that concerns regarding the PRC culture and the impact on providers was not limited to PRC members. Two former clinical service leaders, who were not PRC members, expressed concerns about peer review such as “we’re all afraid as doctors, I think there’s no real psychological safety that people on the peer review will just go for lack of a better phrase, go

⁴¹ Merriam-Webster.com Dictionary, “pejorative,” accessed September 25, 2023 <https://www.merriam-webster.com/dictionary/pejorative>. Pejorative is defined as “a word or phrase that has negative connotations or that is intended to disparage or belittle.”

after us;” and another sharing, “I have heard from four different services or sections from their representatives on peer review . . . that they’ve lost all faith in the peer review process since the arrival of the [DCOS-IO], the new Chief of Staff, and the [ACOS-E.]”

When questioned by the OIG, the COS said, “. . . we had new people in the peer review, and they started questioning the standard of care. . . .” The COS acknowledged that the ACOS-E was aggressive during the first PRC meeting and reported providing feedback to the ACOS-E on how to address patient care concerns at future PRC meetings. The chief of quality, safety, and value described the ACOS-E as being “extremely passionate” at the first PRC meeting and was later encouraged to, “tone it down, even though I agree with what you’re saying, it’s the way you said it is a bit much.”

Key Senior Leaders’ Response to Psychological Safety Concerns

The OIG found that after learning PRC members shared concerns regarding the lack of psychological safety within the PRC and peer review processes to non-PRC members, key senior leaders’ responses focused on ensuring PRC members’ adherence to the confidential nature of peer review process rather than understanding and addressing psychological safety concerns.

Professional literature states that physician performance feedback from peers is imperative for continuous professional development, and physicians who experience increased psychological safety are more likely to receive corrective feedback, and suggestions for improvement.⁴² The need for psychological safety among healthcare teams is important as team members must come together to manage patient safety within the healthcare system. When leaders fail to foster a psychologically safe environment team members avoid speaking up and do not feel safe to share ideas for improvement.⁴³

In an interview a PRC member told the OIG that in February 2023, the COS learned that the peer review process was discussed outside of the PRC and the COS’ response failed to address PRC members concern regarding peer review stating,

[There was] some outside discussion of how bad the process was and [the COS] had apparently gotten word of it because at the subsequent meeting [the COS] did appear to acknowledge the concerns that the process was not being fairly run. But then the response to that was not one that I would say was of introspection or

⁴² Renée A. Scheepers, MSc, PhD; Myra van den Goor, MD, PhD Candidate; Onyebuchi A. Arah, MD, PhD; Maas Jan Heineman, MD, PhD; Kiki M. J. M. H Lombarts., MSc, PhD. “Physicians’ Perceptions of Psychological Safety and Peer Performance Feedback,” *Journal of Continuing Education in the Health Professions* 38, no. 4 (Fall 2018): 250–254, <https://doi.org/10.1097/CEH.0000000000000225>.

⁴³ Roisin O’Donovan and Eilish McAuliffe, “Exploring psychological safety in healthcare teams to inform the development of interventions: combining observational, survey and interview data,” *BMC Health Services Research* 20, no. 810 (August 31, 2020), <https://doi.org/10.1186/s12913-020-05646-z>.

wondering why, it was reminding the members of the committee do not talk about peer review outside of peer review . . . my understanding is that we should not discuss specific details and specific cases.

Another PRC member told the OIG of sharing concerns with a non-PRC member that the PRC was “no longer a safe place to . . . review patient events.” The PRC member reported that no “patient specific or case specific information” was discussed with the non-PRC member. The PRC member said that during the next PRC meeting the DCOS-IO shared awareness that someone expressed concerns about psychological safety outside of the PRC and as a result, the committee members were required to repeat the peer review training. The PRC member said that the DCOS-IO told the PRC members that sharing these concerns was a “violation,” and was “subject to fines and . . . legal ramifications.” Further the PRC member reported feeling the response from key senior leaders failed to assess or address the reasons the PRC member reported feeling unsafe stating leadership’s response was, “. . . you’re wrong, it is safe. Instead of having this curiosity of like why do you think it’s not safe, like this is maybe concerning that someone feels this isn’t a safe place to have these conversations.”

When asked about PRC members perceptions that peer review was punitive and feeling unsafe to voice opinions, the COS did not recall any time that peer review was punitive. The COS further stated a change in culture was needed in PRC to assure that all aspects of the standard of care were met in addition to ensuring impartial and vigorous discussions were taking place. The COS reported learning from the risk manager that a PRC member had shared concerns about psychological safety with a non-PRC member. The COS relayed becoming aware of a second complaint regarding psychological safety in the PRC after the matter was elevated to the former VISN Chief Medical Officer by a clinician who was not a PRC member; the former VISN Chief Medical Officer relayed the clinician’s name and the reported concern to the COS.

When asked about knowledge that a specific case was discussed outside of the PRC, the COS denied knowing this information but reported the primary concern was that a PRC member may have shared protected information. The COS stated,

. . . first of all, it was like, [name of additional, non-PRC member] is not even a part of peer review. So that was a concern it was, again, I think the concern and that’s why we made this special effort . . . let’s make sure that everybody gets a TMS training and having that discussion about what really peer review means.

The COS reported that PRC members were encouraged to follow up with the COS directly or the risk manager to address specific concerns regarding psychological safety within the PRC. The COS shared that no concerns were brought forward. Additionally, the COS told the OIG that the VISN risk manager started attending the PRC meetings across the VISN, and that VISN risk manager attendance at the PRC meetings was helpful regarding concerns of psychological safety within the meetings.

During an interview, the DCOS-IO stated the belief that in prior PRC meetings providers were hesitant to critically review another provider's care of a patient, adding that doing so is not punitive. Further, the DCOS-IO reported,

people who were part of the peer review committee were probably discussing peer reviews outside of the committee, which they shouldn't be doing. It's protected . . . [this] should not have occurred . . . we had this conversation, and there was some repeat training done, during peer review committee meeting as well that these are protected reviews. You cannot just share it.

The DCOS-IO reported becoming aware of these conversations after being notified by the risk manager that PRC members shared concerns outside of the PRC; the DCOS-IO stated the risk manager's primary concern was the violation of a protected activity. The OIG asked the DCOS-IO if PRC members were allowed to have a conversation about psychological safety but not patient specific cases. The DCOS-IO responded, "Yes. So, we don't know if specific cases were discussed or not. I don't know exactly what was discussed." When asked specifically how the DCOS-IO addressed concerns regarding psychological safety, the DCOS-IO stated

first that we addressed was you cannot have discussed cases outside, which we didn't know were discussed or not discussed. We didn't go into that, but we wanted to make sure everybody's retrained . . . the second piece . . . we should be having these robust conversations. These are not punitive, so again, that conversation happened again in peer review committee as well."

When questioned, the ACOS-E told the OIG that peer review meetings were getting better stating, "It's improved significantly." Further stating, ". . . I mean I'm trying to understand what the whole issue behind the peer review process is because in my opinion peer reviews has improved significantly. We have our peer reviews meetings being monitored by the VISN and they thought it was a pretty robust discussion." The ACOS-E further reported supporting a peer review process that includes robust discussions.

Additionally, the ACOS-E stated that peer review is not a punitive process, and the PRC members should not be afraid to ask difficult questions, have intense discussions, and identify areas for improvement.

In July 2023, the COS and the DCOS-IO told the OIG that the PRC meeting culture had improved, and members were comfortable giving feedback and participating in discussions; the OIG noted these opinions contradicted the experiences and perceptions shared by the majority of the PRC members interviewed.

The OIG found that the COS and DCOS-IO focused efforts on their perceived violation that PRC members shared protected information, informed PRC members of the consequences of sharing protected information, and directed members to retake a training course; unfortunately, these

efforts served to further reinforce members' perception that PRC and peer review processes were psychologically unsafe and punitive. The OIG concluded that when learning of PRC members' concerns of psychological safety, key senior leaders missed a critical opportunity to listen to PRC members' concerns and make efforts to foster a psychologically safe environment, which is imperative to patient safety.

AES Results Reflective of Employees' Workplace Concerns

The OIG found that facility employees' 2023 AES responses, particularly employees who either directly reported to or whose service line reported to the COS or the DCOS-IO, reflected concerns with effective and ethical leadership, organizational culture, and workplace satisfaction.

The VA AES was developed in 2001 "to meet VA needs in assessing workforce satisfaction and organizational climate."⁴⁴ The employee survey is a confidential, anonymous feedback tool distributed in June; the AES results are available in late August. Per VHA, the AES is an important tool for all VHA leaders . . .

to understand what their organization is doing well and where improvements can be made. Significant effort is put into analyzing the results to understand, learn and improve with the goal of making each VHA site a 'best place to work' . . .

The way in which leadership engages front line staff members and responds to the information garnered from the AES process has an immense impact on morale, trust, commitment and overall culture of the organization.⁴⁵

The OIG reviewed the facility's 2022 and 2023 AES data including the employee response rate, best place to work score, and the organizational health index (OHI) score and categories to determine if responses were congruent with the information gleaned from employees during OIG interviews.

Best Place to Work

AES "best places to work" scores range from 0–100; higher scores are more favorable. VA employees can view AES results by facility, service line, work group, and occupation. AES results can identify areas that are doing well and those that need improvements. The best place to work score is calculated from responses to three survey questions:

⁴⁴ Osatuke, K., Draime, J., Moore, S.C., Ramsel, D., Meyer, A., Barnes, S., Belton, S., Dyrenforth, S.R. (2012). Organization development in the Department of Veterans Affairs. In T. Miller (Ed.), *The Praeger Handbook of Veterans' Health: History, Challenges, Issues and Developments, Volume IV: Future Directions in Veterans Healthcare* (pp. 21–76). Santa Barbara, CA: Praeger.

⁴⁵ VA, "Linking All Employee Survey (AES) Results, Analysis and Action Plans to High Reliability Organization (HRO) Efforts," May 2021.

- Considering everything, how satisfied are you with your job?
- Considering everything, how satisfied are you with your organization?
- I recommend my organization as a good place to work.

The OIG reviewed the results of the facility’s AES response rate and best place to work scores by facility and by those employees who reported either directly or by service line (roll-up) to the Facility Director, COS, and DCOS-IO.⁴⁶ As the Facility Director was the only key senior leader in their role when the survey was administered in June 2022, table 2 includes VHA, facility, and Facility Director scores. Table 3, 2023 AES scores include three key senior leaders.

Table 2. 2022 Best Place to Work Scores

AES Group	Survey Group	Response Rate (Percent)	Scores 1–100 (Higher Scores are Better)
VHA	All VHA Employees	70	68
Facility	All Facility Employees (n=2,341)	65	61
Facility Director	Direct Reports (n=10)	77	40

Source: VA 2022 AES Dashboard SharePoint, accessed September 27, 2023, and March 18, 2024, <https://dvagov.sharepoint.com/sites/AESDashboard/2021%20AES%20Dashboards%20%20ASPX/1195995%20Eastern%20Colorado.aspx>. (This website is not publicly accessible.)

Table 3. 2023 Best Place to Work Scores by Key Senior Leader

AES Group by Facility and Leader	Survey Group	Response Rate (Percent)	Scores 1–100 (Higher Scores are Better)
VHA	All VHA Employees	74	72
Facility	All Facility Employees (n=2,563)	67	62
Facility Director	Direct Reports (n=10)	83	69
COS	Direct Reports (n=13)	72	36
	Roll-up (n=1,022)	64	59
DCOS-IO	Direct Reports (n=7)	78	27

Source: VA 2023 AES Dashboard SharePoint, accessed September 27, 2023, and March 18, 2024, <https://dvagov.sharepoint.com/sites/AESDashboard/2021%20AES%20Dashboards%20%20ASPX/1195995%20Eastern%20Colorado.aspx>. (This website is not publicly accessible.)

*Facility AES results did not include roll-up service data specific to the DCOS-IO.

⁴⁶ The key senior leader, ACOS-E, was not listed on the facility AES as having employees (direct reports) or services (roll-up) reporting to the position. Therefore, this position is not included in the tables.

When comparing the 2022 and 2023 AES score in the tables above, the OIG found the facility’s score in the best place to work category was below the VHA score. The facility scored 7 points below VHA in 2022 with the span increasing to 10 points below VHA in 2023.

The Facility Director’s direct report employees’ score in the best place to work category increased significantly from 40 in 2022 to 69 in the 2023 survey results; however, the OIG noted that at least six (60 percent) of the Facility Director’s direct report employees in 2023 were newly appointed. Apart from the Facility Director, appointed in 2019, the rest of the executive leadership team consisted of new members who were appointed from July 2022 through January 2023; members of the executive leadership team report to the Facility Director.⁴⁷ As such, the OIG could not determine if the increase was due to staffing turnover, positive changes, a combination of both, or neither.

The COS and DCOS-IO direct report employees and roll-up services best place to work scores in the 2023 results were low. The OIG noted the results to be congruent with the sentiment clinical and administrative leaders and staff expressed in regard to key senior leaders, professional and personal distress, and low morale and dissatisfaction. Similarly, the OIG’s review of AES data revealed the facility’s physician occupational group 2023 best place to work scores decreased significantly (15 points), as depicted in table 4 below.

Table 4. 2022 and 2023 Best Place to Work Scores by Physician Group

AES Group	2022 Score 1–100 (Higher Scores are Better)	2023 Score 1–100 (Higher Scores are Better)
Physicians	65.19	49.79

Source: VA 2023 AES SharePoint by facility and occupational group.

Organizational Health Index

The OHI is “the highest-level summary of AES data” and is “useful for getting a sense for how groups compare overall. . . .”⁴⁸ VHA’s National Center for Organization Development manages the survey and conducts statistical comparisons of AES data; each group within VA is compared to a reference group (VHA facilities are compared to the rest of the VHA facilities). “The OHI score is the number of favorable comparisons minus the number of unfavorable comparisons . . . High scores for OHI Current mean the group compared favorably to its

⁴⁷ The executive leadership team includes the Facility Director, the Deputy Director, the COS, the Associate Director, the Associate Director of Patient Care Services, the Assistant Director of Southern Colorado, and the Assistant Director of Northern Colorado.

⁴⁸ VHA National Center for Organization Development, “VA All Employee Survey (AES) Organizational Health Index (OHI),” 2023.

reference group” that year.⁴⁹ The range of possible OHI scores vary slightly from year to year as items (questions) are added to or removed from the survey.⁵⁰ OHI scores for 2023 ranged from negative 69 (all comparisons were unfavorable) to 69 (all comparisons were favorable).

The facility’s 2023 OHI score was negative 51. In comparison to the reference group of 140 VHA facilities, the facility had zero favorable comparisons, 18 neutral comparisons, and 51 unfavorable comparisons. (See [appendix A](#) for breakdown of comparisons by AES question.) Of the 140 VHA facilities included in the reference group, the facility’s OHI score was in the bottom eighth percentile.

Service and Section Leaders’ Resignations and Vacancies

The OIG substantiated that mid-level leadership had been eroded and found leadership instability at the service level, with many clinical service and section-level resignations and extended vacancies.

According to the VHA National Center for Patient Safety, engaged leaders “are the driving force behind how things function in a health system,” and are essential to creating a culture of safety.⁵¹ The American College of Healthcare Executives states that “healthcare organizations need continuous and effective leadership to be successful and fulfill their mission of delivering quality medical care.” Further, leadership instability has negative consequences and may disrupt activities such as developing new services or physician recruitment.⁵²

The VISN human resources officer informed the OIG the last permanent chief of medicine left the position in September 2020, and as of October 2023, the position remained vacant. The quality section chief provided correspondence that the DCOS-IO was acting in the chief of medicine position, dually holding both positions. When asked about the plan to hire a permanent chief of medicine in July 2023, the COS said facility leaders were interviewing potential candidates for the position. The Facility Director said searches had been conducted for a person to fill the position, and that it had been advertised three times, as of July 2023. In an information request, the OIG learned that as of October 2023, hiring efforts remained in process.

⁴⁹ VHA National Center for Organization Development, “VA All Employee Survey (AES) Organizational Health Index (OHI).”

⁵⁰ VHA National Center for Organization Development, “VA All Employee Survey (AES) Organizational Health Index (OHI).”

⁵¹ “NCPS Approach to Achieving High Reliability,” VHA National Center for Patient Safety, accessed September 19, 2023, https://www.patientsafety.va.gov/features/NCPS_APPROACH_TO_ACHIEVING_HIGH_RELIABILITY.asp.

⁵² “Improving Leadership Stability in Healthcare Organizations: CEO Circle White Paper Winter 2011” Foundation of the American College of Healthcare Executives, accessed October 5, 2023, <https://www.ache.org/-/media/ache/learning-center/research/ceowhitepaper2011.pdf>.

Another clinical leadership position, the chief of hospital medicine, became vacant in June 2022 with an acting chief appointed in July 2022 until the acting chief left federal employment in July 2023, according to a staff member in the COS's office. When asked about the plan to hire a permanent chief of hospital medicine, a member of the COS's office reported the position was in active recruitment as of October 2023.

The OIG learned the ICU director position had also been vacant since at least November 2021 when an acting ICU director was appointed. The OIG was unable to determine when the position first became vacant. Although the OIG asked VISN and facility staff, both reported the date as unknown.⁵³ The OIG learned through correspondence and document review that an acting ICU director was appointed in November 2021 and remained in the acting role until the ACOS-E assumed the role in July 2023.

The OIG found several other leadership positions were permanently filled after extended vacancies including

- the deputy chief of staff for outpatient operations (DCOS-OO), which became vacant in November 2022, was filled in August 2023 by the acting chief of surgery;
- the chief of primary care, which became vacant in September 2022, remained vacant until the position was filled in June 2023; and
- the chief of emergency medicine was vacant while an interim chief was in place from February 2022 until the position was filled in May 2023.⁵⁴

Through document reviews and interviews, the OIG learned of other clinical leaders' who resigned from their positions including

- the chief of hematology and oncology in July 2022,
- the chief of care management and social work in December 2022,
- the chief of CT surgery in March 2023,
- the deputy chief of anesthesiology in April 2023,
- the deputy chief of mental health in April 2023,
- the deputy chief of surgery in April 2023,
- the chief of physical medicine and rehabilitation in July 2023,

⁵³ The OIG determined the position had been vacant since at least November 2021, based on a memorandum that appointed an acting ICU Director at that time.

⁵⁴ The OIG was informed of the interim emergency medicine chief's appointment dates in an interview.

- the chief of anesthesiology in October 2023, and
- the chief of behavioral health in October 2023.

Service leaders and staff reported concerns regarding the absence of permanent mid-level leaders in critical positions and a monopoly of control held by three key senior leaders, two of whom placed themselves in the acting role of mid-level managers. The OIG verified during interviews and through document reviews that several mid-level leadership positions were held by three key senior leaders including the

- COS, who began facility employment in July 2022, also functioned as the DCOS-OO from November 2022 to August 2023;
- DCOS-IO, who began facility employment in January 2023, dually served as the chief of medicine from January through the last update in October 2023; and⁵⁵
- ACOS-E, who began facility employment in December 2022, assumed the dual role of ICU director in July 2023.

Service leaders and staff shared concerns during interviews and through written correspondence.

- “We have not had a Chief of the Medicine Service for almost two years. Instead, the deputy Chief of Staff serves as the interim chief. This is a conflict of interest. In a healthy leadership structure, a medicine chief would be able to advocate for the needs of patients and providers within the section. Instead, we do not have a safe and trusted supervisor, limiting checks and balances for other members of the [executive leadership team].”
- “We have been without a chief of medicine for . . . [two] years now, and the [DCOS-IO] who is currently the interim chief of medicine is clearly overworked with this additional position and is canceling the weekly section chief meetings frequently and on short notice. Essentially, there is no platform for us to discuss and solve issues.”
- “The [new ICU director] [and] acting [chief of medicine] (who is also the permanent deputy chief of staff) . . . have an aligned vision with the Chief of Staff for the future of our medical center that is broadly felt by majority of staff informally surveyed here to not fit accurately with the needs of our Veterans or what our current staff is able to fulfill. . . . There was no discussion with current pulmonary/critical care staff of the potential impacts on our work conditions or impacts on patient care. . . . With this change in ICU leadership (and continued lack

⁵⁵ During an interview, the COS reported the DCOS-IO while not officially detailed to the position, was responsible for the chief of medicine’s role.

of stable/permanent Medicine Service chief), there are now no longer any intervening officials/leaders to temper the executive team's requested/required changes to ICU (and by extension/impact, pulmonary and sleep) operations. I am greatly concerned for [the] staff's wellness and the effects on our patient care offerings."

- "One of my biggest concerns is . . . leadership stability at the service chief line . . . frankly, at the deputy chief line because . . . there is supposed to be a second one and isn't and . . . what that does to the institution in terms of even as the service leaders being affected . . . with . . . constantly moving tentacles, it's an, it's an extra challenge to be effective."
- "In the town hall, there was sort of an ironic exchange, [with] one of the primary care doctors. So, so when the director became very angry after learning that we had been going around the normal chain of command to ask for help and telling us that we were to stop doing that, one of the primary care doctors . . . told him . . . the reason we're doing this is because we don't have anyone to talk to. No one's listening to us. And [the Facility Director] . . . sort of stood over [the primary care doctor] and told [them] you, you're supposed to go through, you need to go through your supervisor and the right chain of command. At which point that primary care doctor reminded him that they haven't had a chief of primary care in four years, and [the Facility Director] didn't seem to know what to do with that. Umm. But again, this like vacuum in the middle is also very, very dangerous because it makes these people step down to places they're not really competent to be, and don't have honestly, the time to manage, they have full time jobs somewhere else, they can't be the chief of medicine as well."

During interviews and through correspondence, multiple staff and service leaders attributed the loss of clinical leaders to the actions and leadership style of key senior leaders. Facility leaders told the OIG

- I don't feel I'm aligned with the current leaderships objectives means of leading. And I felt, I felt over months, tremendous moral injury, and I felt like I couldn't work here anymore. . . . There's this pattern of people being driven out for disagreeing with decisions and sometimes being replaced by people who are perceived to be pliable, 'yes men,' installed into positions. Often what happens is those people wake up at some point and say no to something, and they're booted, and leaves this incredible vacuum. . . .
- I've talked to a lot of clinical section chiefs where they feel demoralized, like they're not being heard. They're raising like safety concerns, and basically it's my

way or the highway and . . . we're losing . . . great people because of that feeling, that culture of . . . blame.

The OIG found that mid-level leadership positions including the chief of medicine and the DCOS-OO, as well as clinical section and service chief positions remained vacant for extended periods. The OIG is concerned, as expressed by the facility staff and leaders interviewed and in written correspondence, that the extended vacancies of these management positions, as of August 2023 led to a monopoly of control among three leaders, leaving facility service and section chiefs limited avenues for communication and no one to advocate on behalf of their services.

Former Leaders' Reasons for Leaving Facility Employment

In an effort to identify the reasons leaders left facility employment, the OIG sent questionnaires to 20 former facility leaders including former members of the executive leadership team, and former service and section chiefs who left employment at the facility from 2021 through 2023.⁵⁶ The OIG received a response from each leader contacted. The OIG utilized the VA exit survey questions, which incorporate HRO principles and values, to develop a questionnaire for former leaders, and included open ended questions to provide a forum for respondents to provide additional information related to the overall questionnaire content.⁵⁷

All former facility leaders surveyed reported that at least one work condition factor was important in their decision to leave facility employment, with the majority reporting poor or unsafe working conditions.

Of the former facility leaders who reported that poor or unsafe working conditions were a factor in their decision to leave facility employment, most provided narrative responses reporting psychologically unsafe working conditions such as, perceiving the Facility Director “is a bully” or “it felt to me like I was being bullied at times,” “there was an overall fear and distrust when it came to the [executive leadership team],” a “paranoid and fearful” culture, and a “toxic” environment.

The questionnaire included an item regarding opportunity factors playing a role in their decision to leave the facility: opportunity for advancement, lack of career progression, or lack of training and development. Of the former facility leaders surveyed, several identified that an opportunity factor was important in their decision.

⁵⁶ The OIG excluded former leaders who remained employed at the facility or in VISN 19. Most of the former leaders reported leaving employment in 2022 and 2023, with two former leaders who reported leaving facility employment in 2021. The OIG did not independently verify either position titles or employment tenure information provided by former leaders.

⁵⁷ VA, VHA, “VHA High Reliability Organization (HRO) Reference Guide Pre-Decisional Deliberative Document - Internal VA Use Only.”

All former facility leaders surveyed reported that at least one treatment and relationship factor was important in their decision to leave facility employment.⁵⁸ Every former leader reported a lack of trust and confidence in senior leaders.⁵⁹

In narrative responses, some former facility leaders included examples of lack of trust and confidence in senior leaders.

- The Facility Director reportedly suggested termination of an employee “because [the employee] disagreed with me in public.”
- A perception that the COS and Facility Director “orchestrated and calculated” the removal of a service leader whom they “had essentially not liked. . . for some time.”
- Lack of trust and confidence in the Facility Director who reportedly “seemed to select and value loyalty to HIM above all else [emphasis in original].”
- “When the new COS joined, we were having to justify everything, and even when we presented data backing what we were saying, it was dismissed.”
- “[The Facility Director] is fully in over his head and despite how poor the metrics are, no one seems to be calling him to the carpet. Between himself and the current COS they have inappropriately targeted, persecuted, and run off multiple managers, service chiefs, etc. It is unclear whether these cases were real, handled appropriately, or were consistent in supporting the [employees’] protected rights but the trends, if anyone bothers to look, at management leaving [the facility] should raise some eyebrows.”
- “[The Facility Director] was/is looking for yes people, and when you are clinical and know something will not work, [the Facility Director] . . . doesn’t like any opposition no matter how constructive.”

When the OIG asked former facility leaders whether unethical treatment factors were important in their decision to leave facility employment the majority of them reported unethical behavior on the part of the leadership or the organization, just under half of them reported harassment or retaliation for voicing concerns, and several reported harassment or retaliation for participating in a complaint process.⁶⁰

⁵⁸ Treatment and relationship factors included lack of trust and confidence in senior leaders, expertise was not valued, poor working relationships with supervisors or coworkers, lack of recognition, and lack of inclusiveness.

⁵⁹ Former facility leaders were able to select multiple treatment and relationship factors. More than half of those surveyed also identified “expertise was not valued” to be an important factor in their decision to leave facility employment.

⁶⁰ Unethical treatment factors included harassment or retaliation for voicing concerns, harassment, or retaliation for participating in a complaint process, and unethical behavior on the part of leadership or the organization.

Of the former leaders who identified unethical treatment factors, a little more than half identified the Facility Director as the involved leader, and some identified the COS as the involved leader. Former facility leaders were asked whether the executive leadership team's culture and values aligned with their own, and all former facility leaders reported a negative response, with some former facility leaders specifically identifying the Facility Director as the involved executive leader.

The OIG asked former facility leaders whether they felt that executive leaders incorporated and practiced just culture, and most reported negative responses citing examples such as fear of blame, culture of fear, failure to defer to expertise or fear of retaliation. Of the leaders surveyed, the majority reported negative responses to the question: did you feel you could share patient or employee safety concerns and anticipate a fair and just response. Some former facility leaders provided examples involving the Facility Director in their narrative responses. The OIG asked former facility leaders whether they felt that executive leaders incorporated and led with HRO principles including culture of safety, respect for people, valuing expertise, and clear communication. Of all the leaders surveyed, most responded negatively.

The OIG asked former facility leaders to share, from their perspective and experiences, the key strengths and challenges with culture and staffing at the facility. The OIG analyzed responses and found common themes: almost all former facility leaders identified a leadership concern in their narrative responses, such as fear of retaliation, feeling a disconnect existed between executive leadership and service chiefs, reporting service chiefs felt left "on an island with no upper-leadership support due to the blaming culture," or "toxic culture," created by executive leaders, which makes it difficult to recruit and retain staff.

While the OIG did not specifically ask former facility leaders about these themes, of the former facility leaders surveyed

- A little less than half provided narrative responses reporting instances of feeling undervalued or disrespected by senior leaders; and
- Some reported experiencing medical concerns related to facility employment such as stress or mental health conditions, a heart condition, and, in one case, a reported permanent disability.

Over half of the former facility leaders surveyed recognized facility staff as a strength in their narrative responses, with examples such as, the strength of the facility are the employees, high collegiality with a "long history of an outstanding medical staff who prided themselves in providing the best possible medical care," or "there are some really good people working there who care a lot about Veterans and the facility." Of significance, is that some of them reported leaving federal service altogether.

The OIG found that former facility leaders identified that poor or unsafe working conditions, lack of trust and confidence in senior leaders and unethical behavior on the part of leadership or the organization influenced their decision to leave facility employment. Additionally, former facility leaders indicated that executive leadership's culture and values did not align with their own, with many also reporting they felt that leaders did not incorporate or lead with HRO principles, and the facility was a psychologically unsafe place to work. The OIG is concerned about the number of former facility leaders who indicated that executive leadership treatment contributed to their decision to leave facility employment.

Lack of VISN Leaders' Oversight

In an OIG interview in May 2023, a week prior to his retirement, the VISN Chief Medical Officer explained having responsibility for the oversight of clinical operations across the VISN.⁶¹ When asked about the number of service chief departures and extended vacancies at the facility, the Chief Medical Officer reported being "peripherally aware" of and concerned about the issue but denied having knowledge about recruitment efforts.

The OIG team interviewed the newly appointed VISN Director in July 2023, who reported serving as the Interim VISN Director from December 31, 2022, until permanently appointed on June 4, 2023.⁶² The VISN Director shared having heard concerns about the Facility Director's leadership style creating a negative environment; however, the VISN Director reported the belief that the Facility Director was making efforts to improve the culture at the facility, although these efforts may have been hampered by actions taken by the Facility Director and the COS to hold employees accountable. As the interview progressed, the VISN Director noted the difficulty of not having a Chief Medical Officer at the VISN and acknowledged the need for her clinical team to increase their oversight and reporting of facility-level concerns.⁶³

The turnover in VISN leadership positions and subsequent vacancy of the Chief Medical Officer, as well as ineffective communication contributed to the VISN Director's lack of awareness regarding the extent of the clinical staffing and culture challenges at the facility.

Related Finding: Lack of Access to and Utilization of Exit Surveys

The OIG determined that the VISN human resources officers failed to ensure that employees voluntarily separating from facility employment had access to exit and transfer surveys.

⁶¹ The OIG learned of the VISN Chief Medical Officer's retirement in an interview.

⁶² Previously, the VISN Director reported serving as the VISN's Deputy Network Director and was responsible for the oversight of administrative operations across the VISN.

⁶³ At the time of the interview, the VISN Director reported the VISN Chief Medical Officer position was vacant.

Additionally, the OIG determined that neither the Facility Director nor the COS were using exit survey data to identify and address employee retention challenges.

VA requires an anonymous, standardized process for collecting information from employees who leave employment to obtain information about their reasons for leaving employment and identify opportunities to improve retention.⁶⁴ All employees who voluntarily separate from the facility or who transfer to a different VA facility “must be offered the opportunity” to complete a VA Exit or Transfer Survey.⁶⁵ VISN human resources officers are responsible for ensuring the “most current version” of the VA exit survey is offered to employees.⁶⁶ Managers and supervisors are responsible for using survey results to “identify challenges to recruitment and/or employee retention which can impact the employee experience” and “develop and implement action plans to address recruitment and employee retention challenges.”⁶⁷

VA employees who exit or transfer from employment must complete a clearance process using the *Employee’s Clearance from Indebtedness* form (VA Form 3248) with exit and transfer survey information via website address links incorporated into the form. The human resources officer, or designated official is required to sign the VA Form 3248 to “serve as proof that the employee was given the opportunity to take the VA Exit or Transfer Survey.”⁶⁸

The OIG asked the 20 former facility leaders surveyed whether they had been provided the opportunity to complete exit or transfer surveys upon leaving facility employment and 14 of 20 (70 percent) denied being provided with an employee exit or transfer survey. One former leader reported that a survey link was provided, however, it did not work, while another reported initially receiving a survey link that did not work but was eventually provided with a working link.

The OIG requested copies of the facility’s form 3248 from the VISN human resources officer and a facility administrative officer. The OIG discovered that both forms contained nonfunctioning hyperlinks to VA exit and transfer forms. The OIG also reviewed the facility internal website where the VISN human resource officer stated the form was “pulled,” and discovered VA Form 3248 was last modified on August 13, 2021, and confirmed it contained nonfunctioning website address links to VA exit and transfer surveys.

⁶⁴ VA Directive 5004, *VA Entrance, Exit, and Transfer Surveys*, May 11, 2021. Voluntary separation includes employees who are retiring, resigning, or transferring to another federal agency. It does not include, “transfers within VA or termination due to performance and/or conduct.”

⁶⁵ VA Directive 5004; VA Handbook 5004, *VA Entrance, Exit, and Transfer Surveys*, May 2, 2022.

⁶⁶ VA Handbook 5004.

⁶⁷ VA Handbook 5004.

⁶⁸ VA Handbook 5004. VA Form 3248 can be customized to “meet local needs.”

The VISN human resources officer informed the OIG that the Office of the Chief Human Capital Officer notified human resources offices and workforce planners on June 29, 2022, of the release of new VA exit and transfer surveys, to allow “employees to take their survey from a non-VA computer;” and provided new website address links. Additionally, the guidance stated that “HR [human resources] offices and workforce planners are reminded that VA Exit and Transfer [Survey] data must be used as part of the comprehensive workforce analysis required for strategic human capital planning to inform actions needed to address recruitment, hiring, and retention problems”; and that actions should be “incorporated in VA Administration and Staff Office-level strategic workforce and succession plans and shared with senior leaders.” On July 27, 2022, the VISN human resources officer sent correspondence to VISN leaders, sharing the new survey website links, stating that exit and transfer survey sample sizes were “relatively low,” and reporting that human resources staff were encouraged to “advertise the new exit and transfer survey links at their facility so that we can gather information from . . . larger sample sizes to drive insights.”

The OIG contacted nine facility administrative officers to understand the facility’s process of distributing VA Form 3248 and providing survey instructions to departing employees. Seven administrative officers reported that it was their responsibility or practice to provide VA Form 3248 and instructions to separating employees; three administrative officers cited concerns with the process including no clear designation of responsibility, a lack of some leaders’ awareness, and lack of procedure, as well as noting the survey was “not well distributed.” One administrative officer identified that the links to exit surveys were nonfunctional and reported escalating the concern to several human resources employees in January and April 2023.⁶⁹ The OIG reviewed seven VA Form 3248s provided by the administrative officers and found that all contained nonfunctional website links to the exit and transfer surveys.

When asked whether exit surveys were provided to separating staff, the COS stated that “we as an organization need to do a better job to see what is happening.” The COS reported that human resources and leadership “should be meeting” and told the OIG a plan is being developed to improve the employee clearance process. Additionally, the COS stated, that it would be “nice,” to obtain exit survey results to obtain a more “formal perspective” of why staff are leaving saying, “what is happening so we kind of have a pulse on what is going on?” When asked whether exit interviews were conducted the Facility Director reported, “HR [human resources] leads, HR is supposed to do exit interviews.” The Facility Director told the OIG of “not typically” receiving exit information.⁷⁰ Given the number of departing service and section chiefs

⁶⁹ The administrative officer told the OIG of the personal practices of sending the working survey website link to departing employees in an email.

⁷⁰ The Facility Director told the OIG that for the year prior to the OIG interview in July 2023, human resources staff provided exit information related to primary care every six months.

and extended position vacancies, the OIG would have expected the Facility Director and COS to actively seek and analyze employee exit data to understand common factors contributing to these departures and implement measures to improve employee retention.

The OIG concluded that despite concerns about low levels of survey completion in July 2022, VISN human resources officers did not ensure links to surveys were functional, which limited the opportunity for separating and transferring employees to complete VA exit and transfer surveys. Further, the OIG found that neither the Facility Director nor the COS sought or utilized exit survey data to identify challenges to employee retention or to develop and implement action plans to address challenges identified.

Conclusion

The OIG substantiated that key senior leaders failed to utilize HRO principles, undermined the stability and psychological safety of service leaders and staff, and created a culture of fear. Key senior leaders created an environment where a significant number of clinical and administrative leaders and frontline staff from a multitude of service lines felt psychologically unsafe, deeply disrespected, and dismissed, and feared that speaking up or offering a difference of opinion would result in reprisal. In a just culture, staff feel safe reporting concerns and trust that actions are going to be “judged fairly.”

The OIG substantiated that, with the addition of the DCOS-IO and ACOS-E to the committee, the culture of the PRC changed to an environment perceived by the majority of clinical PRC members interviewed, as well as non-PRC clinical leaders and staff, to be psychologically unsafe and punitive. The OIG was unable to determine whether key senior leaders used PRC processes to target a physician group. The OIG found that when learning of PRC members’ concerns of psychological safety, key senior leaders missed opportunities to understand concerns and make efforts to foster a psychologically safe environment. When leaders fail to foster a psychologically safe environment, team members avoid speaking up and do not feel safe to share ideas for improvement.

The OIG substantiated that mid-level leadership had been eroded and found leadership instability at the service level with many clinical service and section-level resignations and extended vacancies. Mid-level leadership positions including the chief of medicine and the DCOS-OO, as well as other clinical section and service chief positions remained vacant for extended periods. The extended vacancies of these management positions led to a monopoly of control among key senior leaders, leaving facility service and section chiefs with limited avenues for communication and with no one to advocate on behalf of their services.

Through an OIG query, 20 former facility leaders shared the factors that contributed to their decisions to leave facility employment. All former facility leaders reported that a work factor contributed to their decision to leave the facility, with the majority reporting poor or unsafe working conditions. Every former facility leader reported that at least one treatment and relationship factor was important to their decision to leave, and all reported a lack of trust and confidence in senior leaders. The majority of former leaders reported that an unethical treatment factor was important in their decision to leave. An OIG analysis of responses found common themes among former facility leader responses such as fear of retaliation, feeling bullied, or a “toxic culture.” A little less than half of former leaders reported feeling undervalued or disrespected by senior leaders, and some reported experiencing medical conditions related to facility employment.

Despite employee losses and extended vacancies, key senior leaders failed to seek or utilize employee exit survey data to identify and address employee retention challenges. Further, the VISN human resources officers failed to ensure that employees voluntarily separating from facility employment had access to exit and transfer surveys.

The OIG concluded that the fears and concerns former facility leaders identified as key factors in their decision to leave facility employment echoed the reports and sentiment expressed by existing facility administrative and service-line leaders and frontline staff during OIG interviews. The OIG remains concerned about the ongoing departures of service and section chief leaders, the low morale of staff, and the potential current and future impact on patient safety and services.

Recommendations 1–7

1. The Under Secretary for Health conducts a review of the Veterans Integrated Service Network leaders' awareness and oversight of the VA Eastern Colorado Health Care System's operations including clinical staffing, hiring and retention of qualified candidates, and leaders' adherence to high reliability organizational principles.
2. The Under Secretary for Health utilizes the above review to standardize Veterans Integrated Service Network leaders' roles and responsibilities across the system to ensure each Veterans Integrated Service Network practices structured and robust oversight activities in support of high-quality healthcare delivery at each healthcare facility.
3. The Veterans Integrated Service Network Director conducts a review to determine whether the actions of the Facility Director, Chief of Staff, deputy chief of staff for inpatient operations, and the associate chief of staff for education created and reinforced a culture of fear and failed to adhere to high reliability organizational principles, and takes action as needed.
4. The Veterans Integrated Service Network Director develops and implements an avenue for VA Eastern Colorado Health Care System's employees to provide periodic feedback regarding the culture of safety and leaders' practice of and adherence to high reliability principles.
5. The Veterans Integrated Service Network Director ensures the VA Eastern Colorado Health Care System Director evaluates clinical service leader vacancies throughout the facility and takes actions to prioritize the recruitment and hiring of qualified clinical leaders.
6. The Veterans Integrated Service Network Director ensures human resources officers provide separating and transferring employees access to the most current version of the VA exit and transfer surveys.
7. The VA Eastern Colorado Health Care System Director and leaders actively seek and utilize employee exit survey data to identify challenges with employee retention, develop and implement actions to address challenges, and evaluate the effectiveness of actions.

Appendix A: Facility OHI Comparisons by AES Item

Favorable	Neutral	Unfavorable
	AES Sharing	AES Use
	Civility	AES Use Expectations (%)
	Discrimination (% Yes)	Authenticity
	Reduced Personal Achievement	Best Places to Work
	Resources	Burnout Symptoms: 0
	Servant Leader Index	Burnout Symptoms: 3
	Supervisor Favoritism	Clear Expectations
	Supervisor Listening	Decisional Involvement
	Supervisor Respect	Depersonalization
	Supervisor Satisfaction	Disengaged Percent
	Supervisor Supports Development	Engaged Percent
	Supervisor Trust	Engagement Driver - Development
	Workgroup Communication	Engagement Driver - Emp. Driven Improvement
	Workgroup Conflict Resolution	Engagement Driver - Sr Leaders
	Workgroup Cooperation	Exhaustion
	Workgroup Psychological Safety	Extra Effort
	Workgroup Respect	Goal Aligned Work
	Workplace Diversity Acceptance	Inclusivity
		Innovation
		Intent to Stay (%)
		Moral Courage
		More Than Paycheck
		No Fear of Reprisal
		Opportunity
		Organization Satisfaction
		Overall Satisfaction
		Performance Accountability

Favorable	Neutral	Unfavorable
		Personal Accomplishment
		Personal Recognition
		Process Improvement
		Recommend My Organization
		Skill Development
		Sr Leader Ethics
		Sr Leader Goal Communication
		Sr Leader Info Sharing
		Sr Leader Respect
		Sr Leader Satisfaction
		Sr Leader Workforce Motivation
		Supervisor Address Concerns
		Supervisor Goal Evaluation
		Supervisor Goal Setting
		Supervisor Work-Life Balance
		Talents Used
		Transparency
		Workgroup Collaboration
		Workgroup Competency
		Workgroup Recognition
		Workload
		Workplace Customer Satisfaction
		Workplace Inspiration
		Workplace Performance

Source: VA 2023 AES Dashboard SharePoint site, accessed September 27, 2023.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: May 9, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Leaders at the VA Eastern Colorado Health Care System in Aurora Created An Environment That Undermined the Culture of Safety

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on VA Eastern Colorado Health Care System's culture of safety. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of healthcare for American's Veterans. The Veterans Health Administration concurs with recommendations 1 and 2 made to the Under Secretary for Health and provides action plans in the attachment. Veterans Integrated Service Network 19 provides concurrence on recommendations 3-6 and the Eastern Colorado Health Care System provides concurrence on recommendation 7.

2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal M.D., MBA

[OIG comment: The OIG received the above memorandum from VHA on June 7, 2024.]

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Leaders at the VA Eastern Colorado Health Care System in Aurora Created An Environment That Undermined the Culture of Safety (OIG Project Number 2023-02179-HI-1370)

Recommendation 1. The Under Secretary for Health conducts a review of the Veterans Integrated Service Network leaders' awareness and oversight of the VA Eastern Colorado Health Care System's operations including clinical staffing, hiring and retention of qualified candidates, and leaders' adherence to high reliability organizational principles.

VHA Comments: Concur

The Office of the Under Secretary for Health (USH), based on early discussions and preliminary findings provided to VHA by the OIG, promptly began the recommended review while OIG's work was still underway. The Office of the Assistant Undersecretary for Health for Operations (AUSH for Operations) worked directly with the newly appointed Network Director to review awareness, oversight, and the level of interaction between VHA Program Offices, Veterans Integrated Service Network (VISN) 19 officials, and VA Eastern Colorado Health Care System leadership. VISN 19 is implementing actions to improve awareness and oversight of its facilities, including through the establishment of a VISN Oversight Officer. By July 31st, 2024, the Office of the USH will convene a workgroup of cross-disciplinary leaders to establish a plan to assess VISN 19's newly established processes, provide recommendations, and ensure that best practices are shared throughout VHA, in accordance with High-Reliability Organization (HRO) principles.

Status: In Progress

Target Completion Date: July 2024

Recommendation 2. The Under Secretary for Health utilizes the above review to standardize Veterans Integrated Service Network leaders' roles and responsibilities across the system to ensure each Veterans Integrated Service Network practices structured and robust oversight activities in support of high-quality healthcare delivery at each healthcare facility.

VHA Comments: Concur

VHA is developing policy to clarify VISN leaders' roles and responsibilities with respect to oversight. The draft policy (VHA Directive 1217, VHA Central Office Operating Units) is currently under review by involved stakeholders. The AUSH for Operations will review the draft policy based on the findings from this report to ensure the policy is clear on VISN roles, responsibilities, structured practices, and robust oversight activities across the system in order to ensure a similar situation does not reoccur.

Status: In Progress

Target Completion Date: October 2024

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 2, 2024

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Leaders at the VA Eastern Colorado Health Care System in Aurora Created An Environment That Undermined the Culture of Safety.

To: Director, Office of Healthcare Inspections (54HL03)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. We are highly committed to implementing high reliability principles and practices which creates a culture that is physically and psychologically safe environment for Veterans, caregivers, and staff. We appreciate the opportunity to review and comment on the Office of Inspector General (OIG) report, Leaders at the VA Eastern Colorado Health Care System in Aurora Created An Environment That Undermined the Culture of Safety.

2. Based on a thorough review of the report by VISN 19 Leadership, I concur with the recommendations and submitted action plans of Eastern Colorado Health Care System and VISN 19. These recommendations will be used to strengthen our processes and improve the care that is provided to our Veterans.

3. I would like to thank the Office of Inspector General for their thorough review and if there are any questions regarding responses or additional information required, please contact the VISN 19 Quality Management Officer.

(Original signed by:)

Sunaina Kumar-Giebel, MHA
Director, VA Rocky Mountain Network (10N19)

[OIG comment: The OIG received the above memorandum from VHA on June 7, 2024.]

VISN Director Response

Recommendation 3

The Veterans Integrated Service Network Director conducts a review to determine whether actions of the Facility Director, Chief of Staff, deputy chief of staff for inpatient operations, and the associate chief of staff for education created and reinforced a culture of fear and failed to adhere to high reliability organizational principles, and takes action as needed.

Concur

Nonconcur

Target date for completion: October 2024

Director Comments

The Network Director, in consultation with VISN 19's Office of Human Resources (HR), the Office of Accountability and Whistleblower Protection (OAWP), and the AUSH for operations, has initiated a review of the cited facility officials to determine whether their actions created and reinforced a culture of fear and failed to adhere to high reliability organizational principles. The Facility Director and Chief of Staff are temporarily detailed out of leadership roles and out of the facility until reviews can be completed and, if warranted, appropriate administrative actions taken. The Deputy Chief of Staff for Inpatient Operations resigned effective March 26, 2024, and the Associate Chief of Staff for Education resigned effective March 27, 2024.

Recommendation 4

The Veterans Integrated Service Network Director develops and implements an avenue for VA Eastern Colorado Health Care System's employees to provide periodic feedback regarding the culture of safety and leaders' practice of and adherence to high reliability principles.

Concur

Nonconcur

Target date for completion: July 2024

Director Comments

The Network Director ensured the Interim Medical Center Director developed a process for VA Eastern Colorado employees to ask questions and express concerns. The facility placed a "Ask the ELT [executive leadership team]" button on their website for employees to use to submit their comments or questions. The Public Affairs staff reviews and works with the Interim Director to assign it to the appropriate ELT member who then responds. The submitting

employee has the choice of whether the question and response are made public, allowing staff to anonymously raise concerns, ask questions and provide feedback on things working well. The Network Director participates in employee town halls to share information, answer questions directly from employees and hear employee concerns. The Network Director appointed a special advisor to perform a system-wide review that included assessment of mechanisms for safe quality care with focus groups, review of core processes and patient safety walkarounds at the Eastern Colorado VA Healthcare System. Also, utilizing this feedback, the Network Director and VISN HRO officer will establish a process to empower employees to contribute to a safer work environment, uphold high reliability principles and foster a culture of trust, collaboration, and excellence.

Recommendation 5

The Veterans Integrated Service Network Director ensures the VA Eastern Colorado Health Care System Director evaluates clinical service leader vacancies throughout the facility and takes actions to prioritize the recruitment and hiring of qualified clinical leaders.

Concur

Nonconcur

Target date for completion: July 2024

Director Comments

The VISN 19 Office of HR has formed a cross-functional team dedicated to working exclusively with VA Eastern Colorado Health Care System (ECHCS) to fill their clinical leader job vacancies. The team is actively reviewing vacancies at the Unit Chief and more senior levels. This team is coordinating with the Executive Leadership Team to prioritize recruitment based on Workforce Planning Data. This data is helping the facility maintain a staffing project management plan while allocating resources and developing recruitment strategies. The team's primary goal is to recruit using competitive and non-competitive processes. HR uses services such as USA Jobs, LinkedIn, Professional Journals, and Medical Specialty Organizations to identify the best candidates. Candidates are then grouped into best, well, and basic qualified groups using the rating and ranking method. This team provides regular updates to VISN Leaders and will request additional resources as needed.

Recommendation 6

The Veterans Integrated Service Network Director ensures human resources officers provide separating and transferring employees access to the most current version of the VA exit and transfer surveys.

Concur

___ Nonconcur

Target date for completion: April 2024

Director Comments

The Network Director directed the VISN 19 Office of HR to ensure HR officers provide separating and transferring employees access to the most current version of the VA exit and transfer surveys, to monitor those surveys, and report findings to the executive leadership team. The desired outcomes of the VISN's improvement efforts are to increase awareness of the VA Exit and Transfer Survey and increase employee participation in the VA Exit and Transfer Survey. The updated document including the appropriate links were disseminated on the week of April 8th to all Administrative Officers, Supervisors and Leadership. The HR team has included multiple ways for departing or transferring staff to obtain the survey. The local HR team provided a briefing to VISN HR leadership on the current results and completion of the process on Friday April 12, 2024. They will routinely provide briefs to the facility ELT team starting in May. The local and Network HR teams will continue to work with leaders to proactively advertise the Exit and Transfer Survey to current employees through multiple streams of communication. The VISN requests closure of this recommendation on publication.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 16, 2024

From: Interim Director, VA Eastern Colorado Health Care System (554/00)

Subj: Healthcare Inspection—Leaders at the VA Eastern Colorado Health Care System in Aurora Created An Environment That Undermined the Culture of Safety.

To: Director, Rocky Mountain Network (10N19)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of healthcare for American's Veterans.
2. The Facility Director response to Recommendation 7 is provided on the attached document.
3. VA Eastern Colorado Health Care System and its leadership are committed to ensuring that high reliability principles are implemented to ensure a strong culture of safety and continuous improvement. We have brought in experts in high reliability to further our journey and strengthen our processes and culture. As just one example, and in alignment with the recommendations and the High Reliability principle of "Reluctance to Simplify", a systems redesign project is being initiated to ensure that feedback is solicited from staff during clearance with root causes reviewed and acted upon in the governance structure. VA Eastern Colorado Health Care System is committed to our journey as a High Reliability Organization and ensuring a strong culture of safety.

(Original signed by:)

Amir Farooqi, FACHE
Interim Director

[OIG comment: The OIG received the above memorandum from VHA on June 7, 2024.]

Facility Director Response

Recommendation 7

The VA Eastern Colorado Health Care System Director and leaders actively seek and utilize employee exit survey data to identify challenges with employee retention; develop and implement actions to address challenges; and evaluate the effectiveness of actions.

Concur

Nonconcur

Target date for completion: February 2025

Director Comments

On March 22, 2024, VA Eastern Colorado Health Care System (ECHCS) initiated review of all employee exit/transfer surveys to identify opportunities for continued successes and for improvement and will report the analysis to the Organizational Health Council (OHC) for identification of trends and recommendations for action at the service or leadership level.

ECHCS has an anticipated July 2024 “go live” date for its Lean Six Sigma Green Belt project to create a Light Electronic Action Framework (LEAF) Employee Clearance with a link to a new exit and transfer review. Once implemented, employees will have one consistent tool for clearing station or transfers versus the present process that includes an email of a pdf form, or a copied and hand-written form sent via email to a large email group. The Human Resources (HR) team has provided the information to AO’s [Administrative Officer’s] and Supervisors as an additional tool to ensure that all staff have been given the opportunity to receive the survey. HR will work with the leadership team and staff maintaining the site for any changes or updates needed to information.

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